

TASK FORCE ON HEROIN AND OTHER OPIATE USE
BY NEW JERSEY'S YOUTH AND YOUNG ADULTS

2014 REPORT

**CONFRONTING NEW JERSEY'S NEW
DRUG PROBLEM:**

A STRATEGIC ACTION PLAN TO ADDRESS A
BURGEONING HEROIN/OPIATE EPIDEMIC
AMONG ADOLESCENTS AND YOUNG ADULTS



GCADA

Governor's Council on
ALCOHOLISM & DRUG ABUSE

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Dear Reader,

In your hands, or on your screen, is a document that is an example of government in action. It is the result of a long collaboration between private citizens, various state offices and numerous professionals with specific expertise. I am pleased to present this report by the **NJ Task Force on Heroin and Other Opiate Use by NJ's Youth and Young Adults**. We held public hearings between May and October of 2012 in Trenton, Mendham, Manalapan and Camden. We heard testimony from people in recovery, high-ranking state officials, law enforcement, researchers, academics, national experts, the state medical examiner, lawyers, doctors, prevention workers, treatment providers and- when factoring letters, phone calls and emails- over a hundred members of the public. At the start of each hearing, we listened to the heart-searing testimony of dozens of parents who lost their children to the scourge of heroin and other opiates. The pictures of those young people are scattered throughout these pages.

Permit me a personal note: I first learned about the devastation of prescription painkillers and the new pathway to heroin in the summer of 2005 when I was working as an outpatient therapist at the Hunterdon Drug Awareness Program (HDAP) in Flemington. A 15 year-old kid from a wealthy and stable home was abusing Percocet, Percodan, Vicodin and OxyContin. He said that they were easy to get from medicine cabinets or his friends and that they were viewed as "safer" than street drugs because they were made by multinational companies in pristine labs and prescribed by professionals with medical training. Within a few short years, I treated more people at HDAP and Rutgers for prescription drugs than anything else. I learned that my clients shifted to heroin because it was so much cheaper. Many probably would never have tried heroin if they hadn't become addicted on prescription pills.

On behalf of the Task Force, I'd like to express our appreciation to a number of people, beginning with Governor Christie. His forward thinking policies on expanding the drug courts and signing the Overdose Prevention Act have given us great hope. Governor Christie's support of the Governor's Council on Alcoholism and Drug Abuse and this Task Force are tremendously appreciated. I must thank the late Riley Regan for urging me to create this Task Force. We also wish to thank Neil Van Ess, the Chairman of the GCADA, for making the Task Force a reality. Celina Gray, Rebecca Alfaro and the rest of the GCADA staff have worked tirelessly behind the scenes and deserve to be recognized as well. Eric Arauz, the vice-chair of this Task Force, and I wish to extend our gratitude and appreciation to the rest of the Task Force.

A final note: on behalf of the entire Task Force, I would like to thank the board members, supervisors and staff of the organizations and companies that gave us the time and space to pursue this urgent cause.

Thank you.

A handwritten signature in black ink that reads "Frank L. Greenagel Jr." with a stylized flourish at the end.

Frank L. Greenagel Jr., Chairman

Executive Summary

The skyrocketing use of heroin and other opiates has become the number one health care crisis confronting New Jersey. Drug overdose deaths now surpass the number of deaths resulting from motor vehicle accidents, which had always been the leading cause of accidental death in the United States. This startling fact underscores the urgency of the situation New Jersey now faces.

This is a new kind of drug crisis, one affecting countless young people previously thought to be at low risk of addiction. In 2012 there were more than 8,300 admissions to State-licensed or certified substance abuse treatment programs due to prescription drug abuse, an increase of more than 200% over the past five years, and nearly 700% over the past decade. Forty percent of opiate admissions for treatment involved persons 25 years old or younger.

Many of those affected begin their journey to opiate addiction through legally prescribed pain medications. Once addicted, these young people seek to maintain their supply of pills by whatever means necessary. Once they become unable to afford and obtain these pills, they move on to heroin, which is more affordable, and undeniably more deadly.

Much has been done in recent years to respond to the emerging crisis. Project Medicine Drop, for example, encourages citizens to properly dispose of unused medications before they fall into the hands of adolescents. The Division of Consumer Affairs has modernized security measures to address the problem of forged and counterfeit prescription blanks, and most significantly, the Division recently launched the New Jersey Prescription Monitoring Program (NJMPMP) to deter and detect fraudulent prescriptions, “doctor shopping,” and other dangerous practices and abuses. Three New Jersey universities have pioneered recovery housing programs to provide supportive environments for students in recovery from addiction.

It is especially noteworthy that last year, Governor Christie signed into law the “Overdose Prevention Act,” which will save lives by encouraging persons to seek medical assistance when a drug overdose occurs. The Governor also announced an historic plan to ensure “parity” in mental health and substance abuse treatment benefits for more than 200,000 members of the School Employees Health Benefit program. This plan should serve as a model for wider reform to ensure access to affordable mental health and substance abuse treatment for those in need.

While these recent steps are critically important, there is much left to do. Recognizing the need for a comprehensive and multidisciplinary plan of action to address the prescription drug and heroin epidemic, on March 20, 2012, the Governor’s Council on Alcoholism and Drug Abuse established a Task Force on Heroin and Other Opiate Use by New Jersey’s Youth and Young Adults. The Task Force was charged to present a report with actionable recommendations that would help to stem the tide of this horrific scourge.

In furtherance of this goal, the Task Force held hearings across New Jersey, receiving testimony from parents who had lost their children, parents trying to save their children, young people in recovery, addiction and law enforcement professionals, and all other stakeholders affected by the alarming increase in the use of heroin and other opiates. The lessons learned from the grieving parents who mustered the courage to share their tragic stories were especially important, not only in revealing problems with our current system and practices, but also in highlighting the human aspects of this public health crisis. Guided by all of this expert and lay testimony, the Task Force identified recommended action steps concerning the following specific topics:

Helping People in Need to Find and Access Treatment Services:

GCADA should work with the pharmaceutical industry and other corporate citizens to create an informational “warmline” that offers real time information on how to gain treatment for opioid addiction, both inpatient and outpatient; that helps citizens to navigate the human services system; and that helps citizens understand and exercise their rights under a managed care system. [See Section 3.1.1.](#)

Staying Abreast of Research on Medication-Assisted Treatment:

GCADA should coordinate with the appropriate State agencies, such as the Division of Consumer Affairs and the Department of Health, along with the State’s medical schools and the professional licensing boards representing substance abuse treatment professionals, to develop training materials and curricula to ensure that all treatment professionals understand the benefits and risks associated with the use of medications such as buprenorphine. [See Section 3.1.2.](#)

Reviewing Insurance Practices That Impede Access to Treatment:

GCADA should work with lawmakers, such as the members of the Senate Oversight Committee, to facilitate meaningful discussions about insurance practices that create barriers to mental health and substance abuse treatment. [See Section 3.1.3.](#)

Addressing the “Not in My Back Yard” Impediment to Expanding Treatment Capacity:

GCADA should coordinate with lawmakers on addressing the practice of using land use statutes and ordinances to impede the construction of new substance abuse treatment facilities that are needed to service the addiction treatment needs of local residents. [See Section 3.1.4.](#)

Studying the Need for Treatment in County Jails:

GCADA should authorize the Task Force to hold a hearing to discuss the effectiveness of, as well as the policy and practical challenges in providing substance abuse and mental health diagnostic and treatment services to county jail inmates, using existing programs as models. [See Section 3.1.5.](#)

Developing and Monitoring a Strategic Public Awareness Campaign:

GCADA should work with other prevention stakeholders, including the Division of Mental Health and Addiction Services, the United States Drug Enforcement Administration, and the Partnership for a Drug-Free New Jersey, to coordinate the development of a comprehensive multimedia and multicultural public awareness campaign. This public awareness initiative should become a public-private partnership involving the pharmaceutical and health care insurance industries. GCADA should monitor the impact of the comprehensive public awareness campaign, and refine it as needed. [See Section 3.2.1.](#)

Updating School Curricula:

GCADA should authorize the Task Force – in partnership with stakeholders such as the Department of Education, student assistance counselors, school resource officers, DARE officers, Municipal Alliances, and educators – to coordinate and oversee the effort in updating core curricula standards pertaining to substance abuse and in developing and disseminating updated curricula that address the problem of prescription drug abuse. [See Section 3.3.1.](#)

School-based Peer-to-Peer Programs:

As a component to the effort to update and disseminate school curricula addressing the problem of opiate abuse, GCADA should work with stakeholders, like the Department of Education, to develop and promote peer education and leadership programs – or take advantage of existing programs as appropriate – to design and communicate effective messages to middle school and high school students about the dangers of prescription drug abuse. Similar peer programs should also be developed in colleges and universities across the State. [See Section 3.3.2.](#)

Prescription Abuse Recognition and Reporting Protocols for Educators:

GCADA should explore with the Attorney General and the Commissioner of Education re-convening the Attorney General’s Education and Law Enforcement Working Group, in order to draft appropriate revisions to the Uniform State Memorandum of Agreement between Education and Law Enforcement Officials and address the problem of prescription drug abuse by or affecting schoolchildren. All school staff members should receive training on prescription drug abuse reporting protocols, and on how to recognize the warning signs of such abuse. [See Section 3.3.3.](#)

Recovery High Schools:

GCADA should convene a meeting of stakeholders to consider the benefits and impediments to establishing a regional recovery school as a pilot demonstration project. The stakeholders should consider statutory and/or regulatory changes that might be needed to remove barriers that effectively prevent those in this state from replicating educational programs proven to be successful in other jurisdictions. [See Section 3.3.4.](#)

Programs for College Students:

GCADA should convene a summit of officials from state and private colleges and universities, to discuss and evaluate their substance abuse programs and to encourage all schools to provide a broad spectrum of recovery support services, including recovery housing. Experts from out-of-state colleges that have developed exemplary programs should also be invited to share their experience and perspective. GCADA should also develop a campaign to convince parents of college students to inquire about the substance abuse prevention, treatment, and recovery support services that are offered by colleges in New Jersey and in other states. [See Section 3.3.5.](#)

Taking Full Advantage of the New Jersey Prescription Monitoring Program:

GCADA should promote a legislative initiative to amend the current law establishing the NJPMP to require prescribers and dispensers to register with and use the NJPMP before prescribing or dispensing those controlled dangerous substances with a high risk of abuse. [See Section 3.4.1.](#)

Expanding NJPMP Access to Mental Health and Addiction Service Providers:

GCADA should promote a legislative initiative to amend the current law establishing the NJPMP to expand NJPMP access to mental health professionals involved in the diagnosis and treatment of substance abuse. [See Section 3.4.2.](#)

Linking NJPMP Data with Other States:

GCADA should coordinate with the Division of Consumer Affairs in its efforts to link the NJPMP with the National Association of Boards of Pharmacy (NABP) InterConnect as soon as possible to better detect prescription drug abuse and diversion across state lines. The Division should also continue entering into PMP information-sharing compacts with those states in the New Jersey region. [See Section 3.4.3.](#)

Real-time Reporting of the Prescription Data into the NJPMP:

GCADA should advance a legislative initiative to amend the current law establishing the NJPMP to require that pharmacies provide real-time prescription information to NJPMP, as the prescription is filled or at least within twenty-four hours. [See Section 3.4.4.](#)

Electronic Prescription Orders:

GCADA should collaborate with the Division of Consumer Affairs, in partnership with stakeholders from the insurance industry, managed care providers, and licensed professions involved in prescribing and dispensing, to undertake a study to determine the feasibility of moving toward electronic scripts. [See Section 3.4.5.](#)

Establishing Standards and Best Practices for Managing Pain and Prescribing Painkillers:

GCADA should coordinate with the Division of Consumer Affairs in convening a committee to review professional standards and establish best practices for managing pain and preventing diversion and abuse of prescription medications. The committee should be cross-disciplinary, consisting of representatives from the State Board of Medical Examiners and other licensing boards. [See Section 3.5.1.](#)

Continuing Education for Health Care Professionals:

GCADA should enlist the proposed committee to review professional standards and establish best practices for managing pain and preventing prescription drug abuse and diversion, to work in partnership with the State's medical schools to establish a continuing education program that ensures prescribers and other addiction treatment professionals possess the most current information on pain management, opiate abuse, suicide prevention, and addiction treatment. [See Section 3.5.2.](#)

Part 1

The Need For Urgent Action

In this introductory portion of the report, we lay the groundwork for our recommendations by explaining who we are, why we were tasked to write this report, and why it is so important that people read it.

Part 1.1

The Crisis That Brings Us Together

In recent years, New Jersey has experienced a dramatic surge in heroin and opiate abuse, particularly among persons aged 18-25. There are no signs that the problem is abating. To the contrary, the situation appears to be worsening. The situation demands urgent attention.

For reasons that we will explain in some detail later in this report, a significant increase in the use, and misuse, of prescription pills has paved a new pathway to heroin's doorstep. This treacherous new road, poorly-marked but well-traveled, conveys a new generation of substance abusers to a terrible destination. While everyone on this roadway is suffering, for too many, the journey ends in death – and not just from fatal overdoses. Some lives are taken by drugged driving. Still other lives are lost to suicide. While most New Jerseyans know that heroin kills – which is one of the reasons this drug carries such stigma – they may not realize that opiate addiction is closely associated with suicide attempts. Withdrawal from opioid drugs can lead to severe depression, anxiety, and loneliness, which can precipitate suicidal behavior.

Many victims of opiate dependence begin their journey to addiction with the use of physician-prescribed medicines – substances that bear the imprimatur of modern medical science and are judged to be safe and effective. Those bona fide medications would seem to have little in common with heroin – an illicit drug that goes by the street name “smack,” “dope,” or “junk.” And yet today, we cannot engage in a meaningful discussion about heroin abuse without also talking about prescription painkillers, and we cannot weigh the benefits and risks of those prescription medications without considering the specter of heroin lurking in the shadows.

The line between legitimate medications and illicit street drugs has become blurred, and there is a disturbing new relationship between the doctor's office, pharmacy, and back-alley drug pusher. This complex and dynamic interaction between legitimate medications and illicit street drugs requires that New Jersey's response to the opiate abuse problem embrace a level of interdisciplinary and interagency coordination never before seen in the arena of substance abuse prevention, education, treatment, and law enforcement efforts. It is this unprecedented need for coordination that brings the matter squarely within the core mission of the Governor's Council on Alcoholism and Drug Abuse (GCADA), which is charged by law with the responsibility to “review and coordinate all State departments' efforts in regard to the planning and provision of treatment, prevention, research, evaluation, and education services for, and public awareness of, alcoholism and drug abuse.”

The Council recognized that given the nature and complexity of the prescription opiate and heroin abuse problems, and the connection between the abuse of prescription medications and illicit drugs, it will be necessary to develop an overarching strategy that bridges many professional disciplines and that embraces a wide array of perspectives. To begin the process of developing that statewide strategy, the Council created our Task Force and assigned us to study the causes and effects of the new epidemic, and to develop specific recommendations on how best to address it (Appendix A).

In order to fully understand the nature and impact of our State's evolving heroin/opiate abuse problem, we hosted a series of public hearings (Appendix B). We listened not only to leading experts, but also to ordinary citizens whose lives were forever changed by a problem they could hardly have imagined that they would ever face. Time and again we heard heart-wrenching stories of the hopelessness of addiction. But we also heard heart-warming stories of the hopefulness of treatment. We listened intently to a wide range of creative ideas on how we can prevent young people from becoming ensnared by pain-causing painkillers, and we heard about the importance of early intervention. We now share what we learned in the hope and expectation that it will make a difference.

The testimony we heard confirmed that New Jersey is in the midst of a new drug abuse crisis – one that affects countless young people once thought to be at low risk of addiction. Because opiate medications such as OxyContin, Percocet, Percodan, Vicodin, and Lorcet are prescribed by physicians much more often today than in the past, these drugs are more readily available and can be easily diverted to the black market. These substances can also be found by teens in household medicine cabinets, which have become the equivalent of the liquor cabinets raided by adolescents of past generations. Some of the new victims of opiate addiction, moreover, had been lawfully prescribed pain medications. A disturbing number of the patients who use these prescription drugs individually or in combination become addicted. By whatever means adolescents and young adults first come to use these powerful medications, once addicted, many will be driven to commit prescription fraud, thefts, and other crimes to maintain their supply of pills. Finally, they turn to heroin and other illicit street drugs in a desperate effort to feed their untreated addictions.

This is hardly the traditional path to heroin abuse, and that is one of the things that make the present situation so troubling. *Because readily-available prescription pills have become a gateway drug, heroin is finding its way into the world of people who never imagined that they would ever confront this terrible substance.*

The good news is that there are things that can be done to prevent young people from going down that path. Public awareness of the nature and scope of the problem is critical not only to interrupt the cycle of addiction, such as by educating people on how to recognize the telltale signs of opiate abuse, but also to prevent that cycle from getting started by discouraging the misuse of prescription pills in the first place. It begins by explaining to the public that we are not dealing with the same drug problem that has long haunted our society.

The modern-day substance abuse culture in New Jersey has changed in ways that will no doubt shock those who never before considered the possibility that they or their loved ones would ever suffer from addiction, much less heroin addiction. Many people today do not understand, for example, how a bottle of pills stored in a household medicine cabinet can be linked by a surprisingly short route to heroin that is purchased from street dealers.

Given the new face of opiate addiction, it is not enough that we re-invigorate public awareness campaigns that expose the horrors of heroin. Those past campaigns were highly successful in stigmatizing that substance. Today, however, we must not only repeat and reinforce that traditional anti-drug message, but go further by explaining to the public the connection between prescription pills dispensed by a trusted pharmacist and heroin sold by a street dealer. The problem we face in presenting that message is compounded by the widely-held stereotype of what a person addicted to opiates looks like. Many of the New Jerseyans whose lives have already been affected live in quiet, tree-lined neighborhoods. Their stories defy the conventional stereotype of heroin abuse. It is tragically ironic that when parents believe that their households are beyond the reach of heroin traffickers, their children may be at greater risk of falling prey to heroin addiction. These families fail to recognize their vulnerability, and that, in turn, makes it more likely that they will not take affirmative steps in their households to prevent and deter abuse, and more likely that they will not recognize the red flags of opiate abuse if and when it invades their world.

This means that the message we need to send must be targeted at those in our society who are least likely to read this or any other report about opiate addiction and heroin. One of our greatest challenges will be to get their attention and give them a much-needed kick in their complacency. Unless all New Jerseyans come to understand the nature and extent of the prescription opiate/heroin epidemic, and unless they learn how they can protect themselves from becoming victims of these terribly addictive substances, we will continue needlessly to lose children to a terrible fate.

Substance abuse experts have long understood that denial is a common symptom of the disease of addiction. Denial can paralyze not only those who are themselves drug or alcohol dependent, but also their loved ones. Regrettably, denial is also a common characteristic of our society's reaction to a new substance abuse problem, especially when, as in this instance, recent developments challenge our traditional conception of what heroin addicts and drug dealers look like. It is time to confront our demons. Our State needs an intervention.

We are not the first in New Jersey to sound the alarm. In 2011, the State Commission of Investigation (SCI) held an unprecedented public hearing to address the links between prescription pill abuse and heroin addiction. Last year, the SCI released a report that describes the nature and extent of the problem. This important report, entitled, "Scenes From An Epidemic: a Report on the SCI's Investigation of Pill and Heroin Abuse," explains the link between corrupt medical practitioners, prescription fraud, and organized crime groups, and offers a number of recommendations concerning the need for stronger oversight of the medical community and tougher financial and criminal penalties for prescription drug diversion. The SCI report also comments on the use of New Jersey's Prescription Monitoring Program as an investigative law enforcement tool.

We strongly agree with the SCI's observation that, "[t]he challenges posed by drug abuse have taken on disturbing dimensions that call into question the conventional wisdom regarding gateway drugs and addiction. To address this crisis, the public discussion about establishing a sensible drug policy needs to be broadened and amplified." The SCI report has already made an important contribution to the ongoing conversation, and underscores the need to make the public and their elected representatives aware of the crisis, and the need for a multidisciplinary response that includes, but certainly must not be limited to, law enforcement efforts to arrest and prosecute offenders. The point is simply that the alarms that have been sounded must resonate through every corner of this State, and our collective response to those alarms must

touch upon every facet and manifestation of the opiate and heroin abuse problem. Although we embrace a holistic approach, as shown by the breadth of our recommendations, we cannot overstate the importance of using every means at our disposal to dissuade young people from experimenting with opiates and starting down the path to addiction.

There is much truth to the old saying that an ounce of prevention is worth a pound of cure. That is why we emphasize in this report the urgent need for a public awareness campaign to alert citizens about the problem. Parents, siblings, teachers, classmates, employers, prescribing doctors, pharmacists, nurses, indeed, *everyone* needs to be on the front lines of prevention by helping to forge and reinforce a culture that disapproves of prescription pill abuse, fraud and diversion with the same fervor and persistence with which society has traditionally scorned heroin abuse and trafficking. So long as segments of our society embrace the myth that the abuse of prescription opiates is somehow less dangerous or serious than the abuse of heroin, we will condemn an untold number of young people and their families to the misery of addiction.

We also need to explain that every family needs to act because no family is immune. Everyone today not only needs to take steps to discourage others from abusing opiates, but also needs to be aware of and on the lookout for the warning signs of abuse. *Many of our recommendations are premised on the notion that the optimal point of intervention occurs when opiate medications are first prescribed, if not even before the prescribing physician puts pen to script pad.*

New Jersey already has in place a comprehensive community-based substance abuse prevention infrastructure that features GCADA's Municipal Alliance Program, as well as the Division of Mental Health and Addiction Service's (DMHAS) statewide network of 17 regional coalitions, and a DMHAS funding program for the delivery of evidence-based prevention curricula to families, children, adolescents, and older adults in all 21 counties. The Partnership for a Drug-Free New Jersey for many years also has played a key role in developing and disseminating prevention messages, and has already joined forces with the Attorney General and the United States Drug Enforcement Administration (DEA) to draw attention to the prescription drug abuse problem. New Jersey's prevention system has adopted what is called a Strategic Prevention Framework, which uses data to set priorities and drive the community planning process.

The nature of the current crisis demands an even greater degree of coordination and collaboration in crafting and presenting the prevention messages we need to send to help young people stay off (or get off) the road to addiction. Consider in this regard that some stakeholders focus on overdose fatalities. Others are principally concerned with suicides. The common denominator, of course, is that young people are dying. That fact, more than any other, creates an urgent need for us to re-examine, re-invent, and re-launch our substance abuse awareness and prevention efforts.

It bears emphasizing at this point that the single most important goal set forth in this report must be to deter the misuse of opiate medications and use of heroin. This must be done through a host of means, including not only public education and awareness, but also through better prescribing practices and ways to identify and deter inappropriate prescribing and dispensing, prescription fraud, and illegal diversion.

Ultimately, we must strive to obviate the need for treatment. It is regrettable but undeniable, however, that despite our best efforts at prevention and deterrence, some young people will not heed our warnings and will find themselves in need of rehabilitative services. For them, we must be prepared to intervene as swiftly and decisively as possible. Addiction science confirms the common sense notion that it is easier to treat an addiction at an early stage of this progressive disease, when the patient is still at a lower level of addiction

severity. For those whose addiction is burgeoning, clinically-indicated treatment will be more available, and more affordable. An important goal, for example, should be to diagnose the affliction and provide treatment services before the patient is fired and loses his or her health insurance coverage. And of course, the goal must be to intervene before the person suffers an overdose or attempts to commit suicide, which happens with alarming frequency.

Part 1.2

Employing a “Problem-Solving” Methodology

We think it appropriate at this juncture to explain the approach we have taken in preparing this report. Too often, well-meaning government task forces and blue ribbon panels issue overlong, overly-technical and statistics-laden white papers, blueprints, and colorless documents that wind up on the shelf collecting dust. Some reports don't even make it as far as a shelf.

In other instances, agencies issue reports that are little more than a compendium of “bullet” points, with little or no analysis and explanation as to *why* the problem at issue exists, and *why* and *how* the recommendations would alleviate the problem. It is no doubt true that an advertising campaign needs to send a short, pithy message – one that speaks for itself and requires no elaboration. But the thinking that goes into designing that message must be far more sophisticated than is suggested by the simplicity of the message itself. Executive summaries are fine, indeed are helpful, so long as they summarize penetrating analysis and well-supported findings. In this instance, our Task Force decided not to present our analysis and findings with the level of detail and citation to published authority more appropriate for a peer-reviewed academic study. We nonetheless see a benefit in explaining, if only in lay terms, how we reached the conclusions we drew and arrived at the action steps we propose.

One thing is certain. The subject of this report is too important, and the need for decisive action too urgent, to allow our recommendations to lay fallow. It is also clear to us that non-traditional problems demand non-traditional responses.

It has become fashionable for task forces and government agencies to set numeric goals as targets to be achieved within some specified period of time. By way of example, we might have proposed to reduce the number of young people who abuse prescription drugs or heroin, or the number of overdose deaths, by 50% over the next five years. The problem with that approach, while well-intended, is that when the deadline has passed, if the target number has not been reached, it is impossible to explain why. Nor is it possible to hold anyone accountable for failing to take the steps that were needed to achieve the goal. For this reason, we have chosen instead to outline steps that should be taken as part of a coordinated, multi-faceted strategy to reduce the prevalence of prescription/heroin abuse and overdose fatalities.

The problem-solving approach that we embrace in this report depends on dissecting a complex, multi-faceted problem into discrete sub-problems that are more manageable and that can be addressed by focused, specific actions. (We refer to these problems as “enablers” in Section 2.4). It bears noting in this regard that by design, our report focuses on one aspect of a much larger substance abuse problem. In sharpening our focus to heroin and opiate abuse by adolescents and young adults, we certainly do not mean to minimize

the importance of other facets of the overall drug and alcohol problem. In fact, many of our recommended action steps, when implemented, will necessarily influence how New Jersey addresses other aspects of an entrenched and remarkably diversified substance abuse problem.

Finally, our problem-solving approach is designed to identify action steps that are needed to achieve *realistic* objectives. Consistent with the prayer that is known so well to persons in recovery, we need the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know difference. There may well be some aspects of the prescription drug and heroin abuse problem that we will not be able to solve, at least in the short term. That recognition must not distract us from focusing on the things we can accomplish.

Part 2

Understanding the Circumstances That Contribute to the Problems and the Roles of Partners Who Must Contribute to the Solutions

In this part of the report, we begin to drill down on the nature, extent, and root causes of the problems we need to address, and to identify the various agencies, organizations, and other entities and persons whose contributions to a coordinated effort will be needed if we are to make a real difference.

Part 2.1

The Faces behind the Statistics

New Jersey does not have a substance abuse problem. It has several substance abuse problems. This report draws attention to one of them: heroin and opiate abuse among young people. We begin our analysis of that problem with a few sobering facts and statistics. At one of our public hearings, Dr. Thomas McLellan, former Deputy Director of the White House Office of National Drug Control Policy (ONDCP), offered chilling testimony that helped to put the magnitude of the problem in perspective. He explained to us that,

the prescription opioid overdose problem now in the United States is the number one cause of accidental death. It's startling.... If I said what do you think is killing Americans more than anything else, a very good answer would be car accidents. It's not, its number two. Gunshots are number three. Prescription, not heroin, prescription opioids is the number one cause....

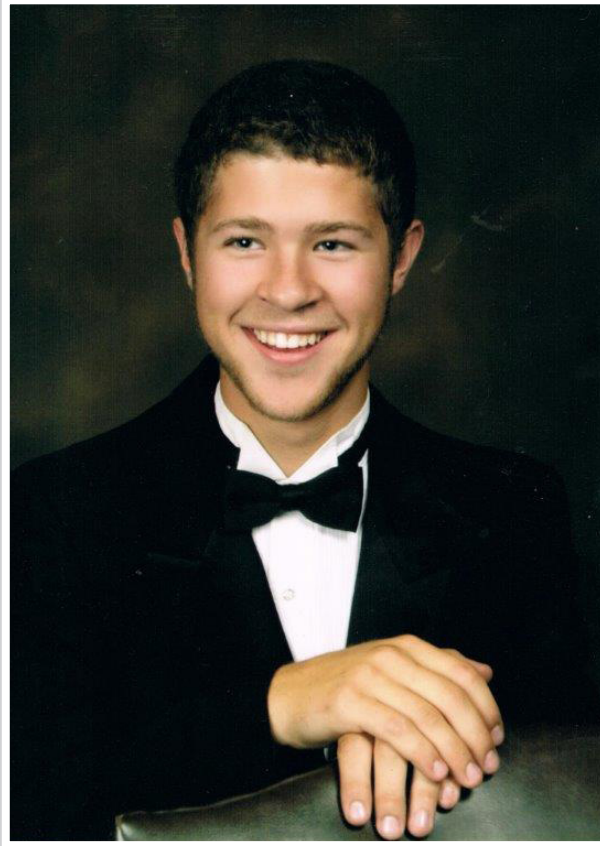
The United States Drug Enforcement Administration (DEA) similarly reports that prescription drugs, including opioids and antidepressants, are responsible for more overdose deaths than so-called “street drugs” such as cocaine, heroin, and methamphetamines.

Consistent with the nationwide experience, Dr. Roger Mitchell, Assistant State Medical Examiner, reports that in the last three years New Jersey's drug-related death toll has risen steadily from 843 deaths in 2010, to 1,026 deaths in 2011, and to 1,294 deaths in 2012. Approximately two-thirds of all those deaths involved prescription drugs rather than solely illicit drugs.

In 2012 there were more than 8,300 admissions to State-licensed or certified substance abuse treatment programs due to prescription drug abuse. That is an increase of more than 200% over the past five years, and nearly 700% over the past decade. One-half of opiate admissions for treatment involved persons 25 years old or younger.

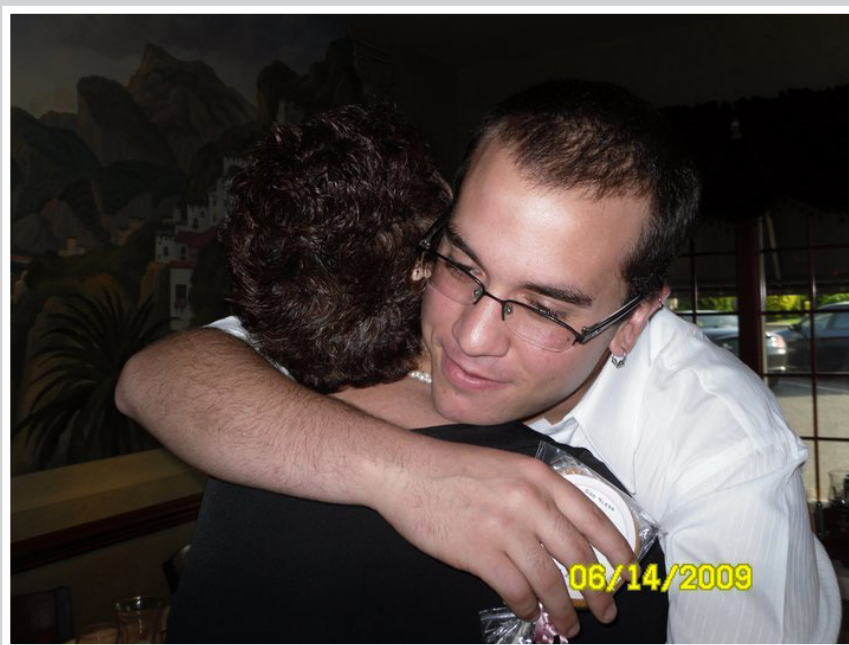
According to a 2012 National Survey on Drug Use and Health compiled by the U.S. Department of Health and Human Services, throughout the country, the number of teenagers and adults who abuse prescription drugs – primarily pain relievers – is greater than those who use cocaine, hallucinogens and heroin combined.

While the foregoing statistics are alarming, and will no doubt come as a shock to many, they only begin to tell the story of how and why our State's drug problem has recently evolved. We can accurately count the number of treatment admissions, emergency room admissions, and overdose deaths, and yet easily miss the import of those numbers. The extent of the suffering experienced by the families of young people who overdosed and died, for example, defies quantification. It is therefore appropriate to highlight just a few of the stories we heard that offer a human perspective on the challenges we face and the need for decisive action.



Megan shared with us how a prescription drug overdose claimed the life of her 21-year-old son, Patrick. Patrick was born with a genetic hip condition that required extensive surgery when he was still very young. The surgery left him in a body cast for two months and caused periodic discomfort throughout his childhood. Megan was always there for her son and raised him to be a responsible young man. She made certain that she knew his friends and their parents, and she encouraged Patrick's friends to come to her house where they would be less likely to find trouble. Patrick began to learn the family trade and was planning to become an integral part of the business.

Patrick was introduced to the prescription painkiller OxyContin while still in high school. He began to use this powerful substance to self-medicate for the pain caused by his hip condition. He soon became addicted to OxyContin and experienced serious withdrawal symptoms when he was without it. Patrick's family fought desperately to get him into the best treatment facilities available. Even so, he relapsed several times. After one short period of being sober, Patrick relapsed for the final time and was found dead on the campus of Fairleigh Dickinson University. He had overdosed on OxyContin.



At another one of our hearings, Dominick, a broken-hearted father, conveyed his thoughts about his son, Chris. Chris could always be counted on for his acts of kindness. He was an above average student, had countless friends, was active in his church community, and was an integral part of his close-knit family. He was loved by his coworkers and the children at the camp where he worked. Chris enjoyed and excelled at athletics and although he was not a natural at any sport, his hard work afforded him the opportunity to play at competitive levels in several sports. Chris was noted for his sportsmanship, win or lose. He earned solid grades, from elementary school through college. He enjoyed learning. Chris was enthusiastic about life.

At some point during his later teen years, Chris and a group of friends experimented with drugs and he became addicted. As the disease progressed, Chris turned to heroin, which was less expensive than other opiates. When he was 19 years old, Chris summoned the courage to tell his parents that he was abusing heroin. The news shook them as they had no idea that he was using drugs, much less that illicit drug. They had simply attributed small changes in his personality to the stress of school and the typical concerns of an adolescent.

Chris readily agreed to go to rehab. He spent a few days in inpatient care before being moved to an intensive outpatient program (IOP) at the same facility. The director of the IOP recommended that Chris “graduate” from the program after only eight weeks so that he would not “over leverage the insurance” in the event of a future relapse. Chris’ parents objected and explained that cost was not an issue and that they were prepared to pay the expense of needed treatment out-of-pocket. The IOP director ignored them and without the courtesy of further discussion, Chris was discharged. For several months, Chris seemed to be alright. He re-enrolled in a college degree program and was doing well. He began to play sports again and proudly stood as godfather to his niece. Once again, he happily joined his family in activities, outings and celebrations. But having been denied the long-term inpatient treatment that he apparently needed, and before anyone in the family could notice, Chris returned to illicit drug use and very soon thereafter died of a heroin overdose at the age of 20.

These stories are repeated over and over in New Jersey. Indeed, every statistic embodies the life (and too often, death) experiences of real people, most of whom suffered for many years before the event that is now recorded dispassionately in a spreadsheet. The aggregate statistics we compile tell us much about the problem, especially with regard to trends. We need those data to inform policy decisions. *But there is more that needs to be learned than can be gleaned by counting numbers. We also need to listen carefully to the people who know the problem from their own experience.*

Part 2.2

The Seductiveness of Cheap, Pure, and Readily Available Heroin

New Jersey has the dubious distinction of having some of the least expensive, highest purity street heroin in the nation. Law enforcement officials report that in New Jersey, the prescription drug oxycodone can be purchased on the black market for \$8 to \$20 per pill. Heroin, in contrast, can often be purchased for as little as \$5 per baggie. In New Jersey, a “dime” bag, apparently, can be purchased at a steep discount.

As it turns out, it is easier, and less expensive, to buy heroin from a street dealer than it is to patronize a so-called “pill mill.” Street heroin has emerged as an attractive option to sate the cravings of prescription drugs. One of the most important themes in this report is the need to debunk the stereotype of the heroin junkie as an urban male with needle-tracked arms nodding off in some dark alley. *Any* person who abuses prescription painkillers can turn to heroin, and many do. For these addicts, street heroin was certainly not their first choice. For too many, however, heroin became their last choice.

One might think that the low price of heroin in this State might result from lower purity levels. To the contrary, our street heroin is vastly stronger than the heroin that is sold in many other jurisdictions. Typical purity levels here exceed 40%. To provide context, in the New England region, the average purity level is around 15%. At bottom, our heroin is cheap. Our heroin is also potent. That is a deadly combination.

The comparatively high purity of heroin sold on-the-street in New Jersey does not at all mean that street-level purity levels are uniform across the State. To the contrary, those levels vary markedly, not only by specific dealer, but also by general location. The DEA reports, for example, that while in some places in New Jersey heroin is often sold at around 40% purity, in other places in New Jersey, the purity level of street heroin has reached 80%.

It should come as no surprise, moreover, that heroin traffickers do not follow FDA-like quality control standards. Dealers may well “brand” their drugs with catchy names and cartoon icons, but the labels on heroin baggies do not provide information on purity concentrations, and do not offer instructions on appropriate dosing. Those who buy heroin on the street must trust their supplier and hope that the latest batch is comparable in origin, quality, and purity to the last batch they purchased. This makes ingesting street heroin like playing Russian roulette. It is especially troubling that novice heroin users – such as those who progressed to heroin from prescription drugs rather than other illicit street drugs – will have neither the personal experience, nor support from other more experienced users, to manage the risk of underestimating purity levels and ingesting too high a dose. Inconsistency in heroin purity, when coupled with the inexperience of novice heroin users, is an especially dangerous combination of circumstances that leads often to overdoses, and death.

We certainly do not mean to suggest that all or even most overdose incidents involve street heroin. Far too many hospital admissions and overdose deaths result directly from the ingestion of prescription pills – medications that had been manufactured in accordance with quality-control standards and that bear dosing instructions and warning labels. Indeed, as we noted in Section 2.1, overdoses resulting from the ingestion of *prescription* opioids are the number one cause of accidental death in America today. The point, rather, is that we cannot ignore how heroin has entered the lives of persons who, according to conventional stereotypes, would not be suspected of falling prey to heroin – a point underscored in Section 2.3.

The high purity level of the street heroin that floods New Jersey’s illicit drug market has other consequences besides the enhanced risk of overdose. The purer the heroin, the easier it is to metabolize the substance in the human body. Today, the heroin sold on the street is so potent that users can get high by snorting or smoking it. Persons who would be reluctant to inject heroin intravenously can thus painlessly ingest it. As a result, one of the natural inhibitions against heroin use – the discomfort and fear of infection associated with hypodermic needles – is avoided. This not only makes heroin more seductive, but also makes it harder for families and friends to detect ongoing abuse. *Many heroin users today cannot be revealed by needle-tracks on their arms. For these users, the scars of their addiction are terribly real, but harder to see.*

Part 2.3

The New Road to Perdition

The law of supply and demand strongly influences the prevalence of substance abuse. It also influences which specific substances become most popular. By way of example, the emergence of remarkably pure and cheap “crack” in the mid to late 1980’s introduced a whole new customer base to the world of cocaine. Decades later, we are still dealing with the ramifications of that sudden shift in product availability and popularity.

Here in New Jersey, the supply of heroin, we are told, has been relatively stable. New Jersey’s unfortunate distinction for having cheap, pure street heroin is by no means a recent development. Law enforcement experts tell us that New Jersey has long experienced a glut of comparatively inexpensive, high-purity heroin as compared to other jurisdictions. Indeed, some law enforcement professionals believe that the resilience of New Jersey’s heroin market has made it more difficult over the last two decades for other illicit street drugs, such as crystal methamphetamine (“ice”), to gain as strong a foothold here as had occurred in many other jurisdictions throughout the United States.

Then what explains the surge in heroin abuse? Clearly, *something* has happened in recent years – something unrelated to or at least not dependent on the price and availability of heroin – that explains the dramatic increase in heroin abuse. It is not enough to attribute the surge to changes in the demand market. That much is obvious. But *why* has the demand for this notorious substance increased? Who is making that demand, and what brought them to that dire situation?

As we noted above, the high purity of the heroin that is available in our State means that it can be inhaled rather than injected intravenously, which reduces one of the natural inhibitions by making administration of the drug less repulsive. Even so, heroin still carries a significant stigma in our society, especially as compared to prescription opiates. People who would not even consider experimenting with heroin are perfectly willing to abuse prescription pain medications. After all, those drugs are medicines, produced in sterile laboratories,

prescribed by trusted doctors, and stored in the familiar amber-colored bottles dispensed by pharmacies, not the dollar-store glassine bags favored by street dealers. Adolescents, who have no qualm about “popping” prescription pills at a party, even without knowing exactly what drugs they are ingesting, would balk were they to be handed a dime bag of heroin. Ease of administration alone, therefore, cannot explain heroin’s new popularity.

The most likely explanation for the surge seems to be that there is a new pathway to heroin abuse – one that is traveled by a burgeoning new class of substance abusers who have progressed from the abuse of *other* opiates. Indeed, very few people start their substance abuse experience with heroin, in part because that drug, despite its disturbing prevalence, still carries such stigma. Prescription drugs, in contrast, are not just legal, but legitimate, representing the hopeful promise of cutting-edge science and technology. We trust the medical profession with our lives, and when both a doctor and government agency tell us that a pill is safe and effective, we accept and rely upon that representation.

While we must be careful not to oversimplify the explanation of a complex problem, it is no coincidence that the recent spike in heroin use corresponds to an increase in the prescribing of painkiller medications. The Centers for Disease Control and Prevention report a 300% increase in the sale of strong painkillers since 1999. There are simply more people lawfully using these prescription substances today than in years past. A subset of that population will abuse the medications that have been prescribed to them, and some of those individuals, in turn, will turn to heroin when the need to do so arises. Furthermore, because opiate prescription drugs are prescribed more commonly than in the past, those drugs are more readily available, not just from pharmacies and “pill mills,” but also from household medicine cabinets.

Understanding the twists and turns of the various pathways to heroin abuse is vitally important because it informs the steps that are needed to put up roadblocks along those pathways. We see at least two distinct routes that need to be cut off. One pathway starts with persons who were not themselves prescribed opiate medications, but who experimented with pain medications that had been lawfully prescribed to others. Some of this type of abuse can be traced to the increased availability of prescription medications that are stored in household medicine cabinets. For countless generations, parents have understood the need to lock the liquor cabinet to prevent their teenage children and their party guests from gaining unauthorized access. Today, parents must recognize the need to take precautions against raiding of the medicine chest.

Another distinct pathway to heroin abuse stems from the course of *bona fide* medical treatment. Some persons become addicted after using opiate medications that were lawfully prescribed to them to relieve pain from an injury or illness. These patients will resort to various means to maintain their supply of the medications that had initially been properly prescribed, lying to their physicians, “doctor shopping,” patronizing unscrupulous physicians and dispensers, prescription fraud, and purchasing those medications on the black market. When those techniques are exhausted, in desperation, they will turn to other opiates that are more affordable and more readily available. They enter the world of cheap, pure heroin.

Illicit drug profiteers, meanwhile, have found a new class of customers in addition to their traditional clientele. The increased demand for heroin and diverted opiate medications has been a boon to street gangs and other organized crime groups that traffic in illicit drugs. Ever resourceful in their marketing practices, some street gangs and other illicit drug distributors today even arrange for convenient home delivery, making it unnecessary for suburban users to venture to unfamiliar urban streets. These traffickers have also

diversified their product line, recognizing that some opiate abusers will prefer illegally diverted prescription drugs to heroin. The new pathway to addiction has provided these gangs with inroads into the suburban drug demand market, extending their turf, market share, and profit margins.

Heroin has long been considered to be one of the most addictive drugs in the world. A significant proportion of those who try it become dependent on it. But with the new pathway, the new breed of heroin user enters the illicit or “street” drug world already opioid dependent. These addicts did not develop their dependence within the culture of the “criminal milieu,” and may not be prepared to handle this new culture. Novice heroin abusers who started the cycle of addiction with prescription drugs may not have colleagues to tutor them in how to prepare street heroin for ingestion. There may be no one to warn them that the heroin sold by certain traffickers is especially potent, or outright mislabeled so that it contains other controlled dangerous substances and not just impurities and unspecified adulterants and diluents. There may be no one to teach these heroin novitiates how to do “tester” shots to check on purity levels. The addicts who came down this new path may also be more likely to ingest the drug while alone, so that when something goes horribly wrong, there is no one around to call for help.

Part 2.4

Identifying the “Enablers” of Opiate Abuse

Our problem-solving approach requires that we identify with a fair degree of specificity various deficiencies in our current policies and practices. For each of these circumstances, which can be thought of as “enabling” the problem, decisive actions need to be taken to address the deficiency.

The circumstances and factors that contribute to the heroin/prescription drug problem and that need to be addressed include, in no particular order of importance:

- Failure to educate the public about the problem and the telltale indications of opiate abuse, including:
 - parents
 - teachers and school administrators
 - employers
- Lack of guidelines and best practices for responsibly prescribing painkillers for those with legitimate pain management needs
- Inadequate professional education of health care providers
- Inadequate patient screening and monitoring (urinalysis, blood tests) to detect and deter prescription drug abuse by patients
- Failure to responsibly dispose of unused prescription drugs
- Reluctance to report overdoses and to seek immediate medical assistance

- Failure of prescribers and dispensers to register with and use the New Jersey Prescription Monitoring Program (NJMPMP)
- Inadequate interstate tracking of prescription data to detect and deter diversion across state lines
- “Doctor shopping” and other forms of prescription fraud
- “Pill mills” run by corrupt physicians or pharmacists
- Insufficient treatment capacity and treatment quality standards
- Insufficient access to quality, *affordable* treatment
- Failure of substance abuse treatment providers to stay abreast of research-based, state-of-the-art treatment regimens
- Insufficient intervention and support services for vulnerable populations, such as college students

All of these enabling circumstances – other than those that fall squarely within the law enforcement community’s bailiwick – are addressed by one or more action steps recommended throughout the remainder of this report.

Part 2.5

Rallying Partners and Stakeholders

As the list of enabling circumstances in the preceding section shows, the problems we face are far too complex and multi-faceted to be solved by any one profession. Rather, it will take a coordinated collaboration of a wide range of professional disciplines, as well as public-private partnerships, to have any significant impact in reducing the incidence and prevalence of opiate abuse. Each partner in this effort has his or her own unique perspective. It is important for all partners and stakeholders to understand their role and contributions in relation to the roles and contributions of others. In the law enforcement world, we are told that this process goes by the name “deconfliction.” It is a means of sharing information to make certain that the efforts of one agency do not work at cross-purposes with the efforts or operations of another agency.

In this section, we mention some important partners – in no particular order of importance – with the understanding that their needed contributions will be explained in more detail elsewhere in the report.

Prevention Community

As we have already noted, New Jersey’s community-based substance abuse prevention infrastructure is comprised of an impressive array of partners. This list includes GCADA’s Municipal Alliance Program, which involves over 380 Alliances encompassing over 500 towns, and the 17 regional coalitions overseen by the Division of Mental Health and Addictions Services (DMHAS). Together with the Partnership for

a Drug-Free New Jersey, the New Jersey Prevention Network, and the United States Drug Enforcement Administration, New Jersey already has in place the expertise, experience, and commitment to mount the kind of coordinated, multidisciplinary public awareness effort that will be needed to reach a whole new target audience of individuals who are at risk but do not know it.

In discussing “prevention” efforts, we must not limit our focus solely to the steps that must be taken to convince young people not to abuse opiates. We must also consider the need to prevent suicides. As we noted in our opening section, withdrawal from opiate addiction is often marked by severe depression, anxiety and loneliness, making this a specific time when suicidal behavior rises dramatically. It is therefore vitally important that we work collaboratively with New Jersey’s suicide prevention groups.

Substance Abuse Treatment Community

When a person falls prey to opiate addiction, there is no viable alternative to treatment. State prison will not staunch the supply of illicit and diverted drugs, much less quell demand, which drives the entire black market. We need to work collaboratively with treatment providers and other members of the treatment community to convince the public that substance abuse treatment works, and deserves a greater share of our funding allocations. In pursuing that objective, we must also work with the treatment community and other professions to establish evidence-based standards for all treatment services, taking full advantage of the latest advances in addiction science.

Health Care Professionals and Licensing Boards

The vast majority of health care practitioners are dedicated professionals committed to a noble cause and the fundamental principle to do no harm. They are critical partners in our recommendation to develop best practices for prescribing painkillers, detecting abuse of those medications, and referring patients to accessible and clinically-appropriate substance abuse and mental health treatment when needed. These professionals also have a keen interest in developing systems that expose the small number of doctors and pharmacists who are either incompetent or corrupt, and taking swift action to strip bad actors of the professional licenses that allow them to deal.

Middle School, High School, and College Communities

We must work closely with middle schools, high schools, and colleges to enlist their support in raising awareness and implementing programs to teach members of these school communities to recognize the telltale signs of heroin and prescription drug abuse. Schools and colleges also present a forum for peer-to-peer education initiatives, such as the collaborative program developed by National Council on Alcoholism and Drug Dependence-Middlesex and Rutgers University known as “Generation Rx,” which conveys the dangers of prescription drugs and collects data used to inform policy decisions. Secondary schools and colleges can also provide safe havens where students in recovery can find security and support.

Pharmaceutical Industry

It is important that we work closely with the pharmaceutical industry. The official State of New Jersey website describes our State as the “Medicine Chest of the World” with 17 of the world’s 20 largest pharmaceutical leaders located here, constituting a \$24 billion industry.

Many pharmaceutical companies are working diligently to develop painkilling medications that are harder to tamper with or abuse. In furthering the spirit of responsible corporate citizenship, we should look to partner with this industry in implementing some of our recommended action steps, such as establishing an informational “warmline” to help people find and access treatment services.

Insurance Industry

We also need to reach out to the health care insurance industry, which would benefit directly from a reduction in prescription fraud. The insurance industry already works closely with the Attorney General's Office of Insurance Fraud Prosecutor. These companies can also become important partners in developing and implementing public education and awareness programs as part of a strategic prevention initiative.

Law Enforcement Community

Our law enforcement colleagues are the first to admit that the prescription fraud and heroin trafficking problems cannot be solved simply by making arrests and prosecutions. Importantly, law enforcement executives in this State, we are pleased to report, also recognize that substance abuse addiction is a disease, and must be treated as such. That is why the law enforcement community has strongly endorsed the New Jersey Drug Court Program, which in many cases offers court-ordered drug rehabilitation in lieu of an otherwise mandatory term of imprisonment. But at the same time, we agree with our law enforcement partners that some people need to be arrested and imprisoned, and their ill-gotten assets seized and forfeited. That is especially true for the new breed of profit-minded drug trafficker – the one who may have attended medical or pharmacy school and may wear a white lab coat rather than fly the colors of a street gang.

Recognizing the magnitude and urgency of the problem, New Jersey's Office of the Attorney General has formed a task force to coordinate the law enforcement community's contributions to the effort to address the opiate and heroin abuse epidemic. We will rely upon that task force to make specific recommendations with respect to needed refinements to criminal drug laws and efforts to enhance and prioritize the investigation and prosecution of "pill mills" and other forms of prescription fraud and diversion.

Aside from prosecuting drug profiteers, law enforcement has a supporting role to play in substance abuse prevention. We were particularly impressed by a program developed in the town of Sparta in Sussex County. We learned at one of our public hearings that due to fiscal problems, Sparta experienced a significant reduction in the number of police officers. The town could no longer afford to pay for a School Resource Officer. Committed to supporting drug prevention, the police department established a program where selected students are "deputized" and accompany officers at special events and drug education classes. The program, which is supported by privately-raised funds, is designed to establish positive role models and turn peer pressure against substance abuse. Later in this report, we highlight the need to develop and expand peer programs as a way to spread important, age-appropriate messages about prescription drug abuse.

Throughout the remainder of this report, we will highlight some of the specific contributions that these partners and other stakeholders can make toward implementing the action steps that we recommend.

Part 2.6.

Recognizing Recent Efforts

Our Task Force is by no means writing on a blank slate. Rather, our recommended action steps build on a solid foundation of efforts that have recently been taken in response to the emerging heroin/prescription opioid epidemic. We therefore believe it is appropriate to describe a few of these recent initiatives.

Part 2.6.1

Project Medicine Drop

More than once, the Task Force heard testimony about the important role of “take-back” programs in limiting the supply of prescription drugs available for abuse and, perhaps even more importantly, in getting people to appreciate the dangers of prescription drugs and unsecured, over-filled medicine cabinets. Since its launch in November 2011, Project Medicine Drop has become a key component of the State’s efforts to broaden public awareness about prescription drug abuse and curb the diversion of prescription drugs. Developed and overseen by New Jersey’s Office of the Attorney General and Division of Consumer Affairs, the take-back program allows New Jerseyans to dispose of unused and expired medications anonymously, seven days a week, 24-hours a day, at “prescription drug drop boxes” located within the headquarters of participating police departments throughout the state.

New Jersey’s Project Medicine Drop builds on the successes of the U.S. Drug Enforcement Administration’s National Take Back Initiative, as well as the American Medicine Chest Challenge, which is sponsored in New Jersey by the DEA, the Partnership for a Drug-Free New Jersey, and the Sheriffs’ Association of New Jersey. Both of those programs provide single-day opportunities to drop off unused medications.

Project Medicine Drop, in contrast, provides the opportunity to discard unused prescription medications every day throughout the year. The participating police agencies take custody of the deposited drugs and ensure their secure and responsible destruction. They report the quantity of discarded drugs to the Division of Consumer Affairs on a quarterly basis.

Since the launch of Project Medicine Drop, New Jerseyans can now dispose of their unwanted medication at 74 secure locations statewide, with multiple locations in each county and plans for even further expansion (Appendix C). Over 17,500 pounds of discarded medication has been recorded to date. That amount is expected to grow dramatically as the Division launches a mobile take back initiative that brings Project Medicine Drop secure disposal containers directly to New Jerseyans at community events across the state.

Notably, the destruction of the drugs comes at no cost to New Jersey taxpayers. In partnerships endorsed by the State Department of Environmental Protection, two nationwide energy-from-waste and renewable energy companies -- Covanta Energy Corporation and Wheelabrator Technologies, Inc. -- have agreed to incinerate the unwanted medication free of cost at their New Jersey waste combustion facilities. A true public and private effort, Project Medicine Drop stands as precisely the type of program where the State, in partnership with the corporate sector, is making a real difference in addressing this public health crisis. We support Project Medicine Drop and its continued expansion for providing a safe and convenient way for New Jerseyans to dispose of their unused medication and for helping reshape the way people think about their prescription drugs.

Part 2.6.2

Prescription Blanks

The soaring rate of prescription drug abuse in New Jersey has fueled an increased demand for fraudulent or forged prescription blanks. Prescription blanks are the printed pads that doctors use to record handwritten prescription orders. The Division of Consumer Affairs, which oversees the New Jersey Prescription Blank (NJPB) program, has made recent strides in modernizing the security measures of the NJPB, making it more difficult to alter or counterfeit prescription orders. This undertaking has taken on particular importance in an age where computers and color printers have become much more sophisticated and much less expensive, making the tools for counterfeiting NJPBs readily accessible to those looking to capitalize on the prescription drug black market.

In regulatory changes that became effective in February 2014, the Division introduced a host of enhanced, print-based security measures for the NJPBs, including microprinting, thermochromic ink, and a hidden word “void” feature that makes evident any attempt to alter the NJPB. These advancements, once implemented, will likely put us ahead of most forgers and counterfeiters, at least for the time being. We commend the Division for its recent efforts, but feel constrained to note that if we are to stay ahead of black market dealers, we will need an even more progressive approach, taking full advantage of advances in computer and telecommunications technology. See Section 3.4.4.

Part 2.6.3

Best Practices for Pharmacies

Stolen or fraudulently obtained prescription drugs inevitably make their way into the hands of those seeking to abuse them. An effective multi-tiered strategy to deal with prescription drug abuse and diversion must include changes to dispensing practices that account for the escalating problem of theft, fraud, and abuse. On May 1, 2013, as part of an initiative launched by the Division of Consumer Affairs, the New Jersey State Board of Pharmacy for the first time published a set of best practices for the secure handling and dispensing of prescription drugs.

This list of sensible security practices, developed over the last year in close partnership with government and industry, represents the best steps pharmacists can take to protect their inventory from diversion and ensure that medication is dispensed only according to a valid prescription, and all pharmacists are encouraged to adopt them (Appendix D). They include specific recommended measures, above and beyond those currently required by New Jersey’s Pharmacy and Controlled Dangerous Substances (CDS) Regulations, such as storing all Schedule II and III medications in a steel cabinet or secure refrigerator that is locked at all times and only accessible to a licensed pharmacist; utilizing video surveillance technology anywhere CDS is stored or handled; maintaining a “perpetual” inventory list of Schedule II and III medications to better account for and detect missing medication; and registering with and accessing regularly the New Jersey Prescription Monitoring Program when filling prescriptions to monitor for instances of doctor-shopping or abuse.

We applaud the Board of Pharmacy and the participating stakeholders for boldly recognizing the need for stronger dispensing safeguards, and we encourage the Board to now incorporate those sensible measures into regulation.

Part 2.6.4

Prescription Monitoring Program

In January 2012, New Jersey publicly launched the New Jersey Prescription Monitoring Program (NJMP). Established by state law, the NJMP is a statewide database that collects prescription data on controlled dangerous substances and human growth hormone (HGH) dispensed in outpatient settings in New Jersey, and by out-of-state pharmacies dispensing those substances into New Jersey. Pharmacies are required to submit the prescription data at least twice per month. As of March of this year, the NJMP has collected data on approximately 25 million prescription sales of CDS and HGH.

This information is readily available to practitioners. New Jersey licensed prescribers and pharmacists may register for NJMP access free of charge and view the CDS and HGH prescription history of a patient. As a tool for better-informed care, the NJMP can be used to supplement a patient evaluation, confirm a patient's drug history, or document compliance with a therapeutic regimen. When prescribers or pharmacists identify a potential sign of drug abuse or diversion, such as when the prescription history indicates the patient is engaging in "doctor shopping" – visiting multiple doctors to obtain prescriptions for the same medication that they then have filled at different pharmacies – they may refer the patient to a drug treatment program or, when appropriate, notify law enforcement about possible illegal activity.

Prescribers can also benefit from the NJMP's "self-lookup" function, through which the practitioner can search the full record of CDS or HGH prescriptions written in his or her name. In many instances, this has alerted doctors to incidents in which their name and CDS number were used on forged or stolen prescriptions, leading to criminal investigations and prevention of further fraud.

In addition to tracking the prescription drug history of a patient, the NJMP monitors the prescribing and dispensing practices of healthcare practitioners and pharmacists. It is an invaluable tool for law enforcement in identifying those professionals involved in prescribing or dispensing outside the prevailing standards of medical practice and in violation of criminal laws. The Division of Consumer Affairs assigns experienced drug diversion investigators to review aberrant prescribing and dispensing behavior identified through the NJMP, and it regularly refers those matters to the appropriate criminal authority or professional board for investigation. Law enforcement agencies also have the ability to request prescription monitoring information by submitting to the administrator a grand jury subpoena, or a court order accompanied by a certification of a *bona fide* investigation.

The recent establishment of the NJMP is a tremendously significant development, and in Section 3.4 of this report, we offer a number of specific recommendations on how to enhance and expand the program to take full advantage of its capabilities in detecting and deterring prescription drug abuse, fraud, and diversion.

Part 2.6.5

Overdose Prevention Act

On May 2, 2013, Governor Christie signed into law the "Overdose Prevention Act" (Appendix E). The new law embraced by the Governor will save lives by encouraging persons to seek immediate medical assistance whenever a drug overdose occurs. In those situations, every minute counts. In the past, there have been

instances where persons were unwilling to call authorities for help for fear that this might lead to an arrest or prosecution for illegal drug use or possession. The new law recognizes that the need for emergency medical treatment outweighs the need to make arrests and prosecutions for drug possession or use. The Governor and the Legislature have determined that lives can be saved by alleviating the fear of arrest and prosecution that might discourage or delay a call for help. To accomplish this vital goal, the new law provides protection in the form of immunity from arrest, prosecution, and conviction for a use or simple possession charge when a person, in good faith, seeks medical assistance for him/herself or another.

To ensure that the law is properly implemented, the Attorney General, as the State's chief law enforcement officer, recently issued a directive that instructs police and prosecutors on the requirements of the law and how to apply it fairly and uniformly (Appendix F). Embracing the spirit of the law and not just its literal text, the Attorney General directive to police and prosecutors extends the immunity feature to persons who were present and collaborated in making the call for medical assistance, and not just to the person who actually placed a call for help to 9-1-1. The task now is to make certain not only that all law enforcement officers are aware of the law and Attorney General Directive, but also that all citizens know about the law and the Attorney General's commitment to enforce it.

Aside from its impact on law enforcement responses to an overdose situation, the new law is also designed to promote the wider prescription and distribution of naloxone, which is an inexpensive and easily administered antidote to an opioid overdose. The new law recognizes that overdose deaths can be prevented by making naloxone and similarly-acting antidotes more readily available to those at risk of an opioid overdose, and to their families and peers.

Part 2.6.6

Rutgers and William Paterson University Recovery Housing

Three Universities in New Jersey have recovery programs that offer special on-campus housing for students who are in substance abuse recovery and are actively involved in 12-step programs. These students also have access to individual and group counseling provided at the universities' counseling centers.

In 1983, Rutgers University in New Brunswick created what was then only the second college-based recovery program in the nation, and in 1988, became the first school in the country to offer recovery housing. Since that time, more than 500 students have taken advantage of this service. In 1993, Rutgers University Newark began to offer recovery housing, and was joined in 2010 by William Paterson University. These housing programs were made possible in part by a three-year grant awarded in 2008 by the New Jersey Division of Mental Health and Addiction Services (DMHAS). The grants covered some of the cost of staffing and also allowed the colleges to provide scholarships to recovering students in need.

Research shows that the recovery housing programs can be very effective. Data collected over the course of the last 15 years shows that when a student in recovery lives in a traditional college setting, he or she has only a 20% chance of staying sober. In contrast, students who live with other people in recovery in a supportive, on-campus environment have an 80% chance of maintaining sobriety. Remarkably, over the last four years, Rutgers recovery housing reports a 95% abstinence rate, a 98% retention rate, and an average grade point average of 3.18. Our Task Force applauds these enlightened programs, and in Section 3.3.5, we urge other colleges to replicate them.

Part 3

Dissecting the Problems and Devising Workable Solutions

In this Part of the report, we break down the various problems and propose specific action steps that need to be taken.

Part 3.1

Enhancing Access to Quality, Clinically-Appropriate Treatment

As we noted in Section 1.1, there is no more important goal than to deter and prevent the abuse of prescription drugs and heroin. When our prevention and deterrence efforts are successful, we obviate the need for addiction treatment. We have nonetheless chosen to begin to confront the “enabling” circumstances identified in Section 2.4 by examining some of the barriers that prevent opiate addicts from gaining timely access to clinically-appropriate substance abuse treatment in New Jersey. We do this not because this topic presents “low hanging fruit” among the suite of needed reforms that we propose. To the contrary, addressing the barriers to treatment is among the most difficult tasks that we lay out. We nonetheless start with this challenging topic out of respect and admiration for the parents who came to our public hearings and shared with us the heartache they endured while trying to find appropriate and affordable treatment services for their loved ones. We felt their frustration and feel compelled now to relay their message in the hope that no parent in the future will suffer the same tragic consequences that result when needed treatment is denied.

The myriad issues surrounding access to substance abuse treatment are among the most complex that we will address in this report because there are competing economic, fiscal, and public policy interests at stake. We appreciate that on some points there will be earnest disagreements among the stakeholders. Even so, we must take this opportunity to engage that debate, and to initiate a frank conversation with the public, including especially the great number of New Jerseyans who still have no conception that they might someday struggle to find substance abuse treatment services to save the life of *their* child.

It bears noting at this point that despite our decision to analytically dissect the evolving opiate/heroin problem into smaller pieces, the enabling circumstances we have identified are tightly interwoven. By way of example, when the public awareness campaign we call for in Section 3.2 is successfully implemented, more citizens will come to realize that expansion of New Jersey’s substance abuse treatment capacity will not just be for the benefit of someone *else’s* child living in some *other* neighborhood. Our citizenry supports hospitals and ambulance squads in all corners of the State because we all know instinctively that the time may come when we will have an urgent need for those health care services. We plan for medical emergencies and make certain that adequate resources are at the ready when needed. People in this State must come to realize that the same foresight is needed with respect to mental health and addiction treatment services.

Part of the problem is that comparatively few people realize that they need those services even when they are already confronting an active addiction, much less before they actually start down the path to drug dependency. That is part of the nature of a disease that presents denial as a common symptom. But whether

as a result of denial, widespread indifference, or just shortsighted public policy planning, the fact remains that most people who need substance abuse treatment will live, or die, without ever getting it. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that in New Jersey, only 6% of youth and young adults who are in need of treatment for chemical dependence are provided treatment—14,200 out of 234,000.

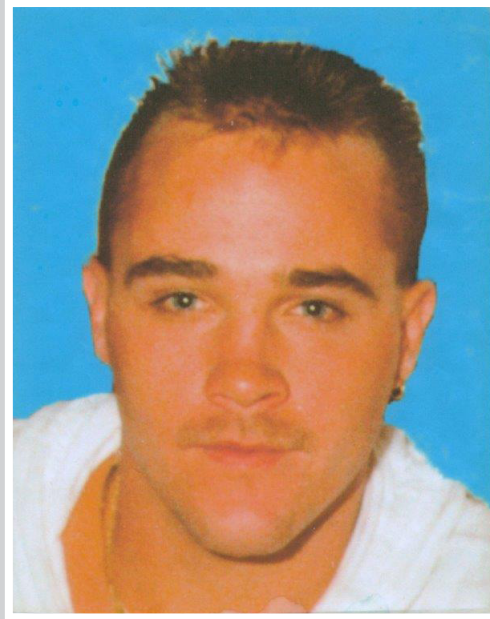
Clearly, we need to do much more to provide both incentives and opportunities for young people in need of treatment to actually receive treatment. To make that happen, we need to confront the current barriers to treatment including inadequate capacity and the high cost of treatment services.

And we need to act swiftly. As our State redoubles its efforts to shut down “pill mills” and prescription fraud schemes, and as pharmaceutical companies develop new ways to manufacture products that are more abuse-resistant (*e.g.* pills that cannot be crushed for faster ingestion in the digestive tract, or that cannot be liquefied for intravenous injection), we can anticipate a spike in the demand for treatment. That can be a very positive development if we are prepared to meet that demand with available and affordable treatment opportunities. Otherwise, ironically, our efforts to reduce the supply of illegally-diverted prescription painkillers will force even more untreated addicts to turn to street heroin. It boils down to a simple choice: we can step into the breach and meet the coming demand for prescription abuse treatment services, or we can leave it to profiteering drug traffickers to meet an increased demand for heroin, knowing full well that they stand ready and willing to do so.

While that choice may sound easy, in fact, it will be no simple task to eliminate certain barriers that keep those suffering from addiction from the treatment interventions they need. As we have already noted, this topic raises exceedingly complex issues, and there are many different perspectives on how best to address the current impediments to treatment. Not surprisingly, different options are advocated by various interest groups and constituencies. Delay is not one of those options. Sir Isaac Newton long ago discovered that a body in motion will remain in motion unless acted upon by another force. The same principle holds true for those suffering from addiction. They will continue to use drugs, indeed, will likely increase their use, until they are stopped by some external, intervening force (hence the term, “intervention”). That positive influence may come from family, friends, schools, clergy, employers, or judges in the criminal justice system. Sometimes, regrettably, the external force that interrupts the addiction cycle is death. *The one thing that is certain in all of this is that being put on a waiting list is NOT an intervention. Like justice, substance abuse treatment delayed can be tantamount to treatment denied.*

During our public hearings, we heard several accounts of how difficult it is to find clinically appropriate treatment. We have already presented the story told by Dominick (page 18), whose son, Chris, was “graduated” from a program against his parents’ wishes with the ultimate result of depriving him of the long-term inpatient treatment that apparently was needed and that might have prevented his untimely death.

This disturbing theme was repeated over and over during our public hearings.



Kass told us of how her son, Christian, struggled with a heroin addiction as a young adult. Christian became involved in the criminal justice system by committing driving while intoxicated offenses, resulting in thousands of dollars in fines. One day, Christian called his mother to tell her that he needed help. Kass rushed to pick up Christian and bring him directly to a treatment facility. The facility initially rejected him because he did not have a referral, so Kass instructed Christian to lie and say that he was suicidal. She knew that it would be the only way he would be admitted. That worked, to a point.

After a short stay, Christian was discharged. Christian had outstanding warrants for his failure to pay fines, so he went to the police department and turned himself in. He spent a few months in a county jail. When he was released, he sought treatment for his heroin problem. Christian and his mother persistently called several treatment facilities begging for help. Kass told us that one facility would say, “Call back Tuesday, next Tuesday.” Every Tuesday they would dutifully call, only to hear, “Sorry, there is no bed available. Call next Tuesday.”

Kass received a phone call one Sunday morning. She learned that her son was unresponsive on the lawn of a friend’s house. He had been lying there for over six hours. No one had called the police. Christian’s father rushed over and attempted to provide mouth-to-mouth resuscitation, but it was too late. Christian had died while on a waiting list for treatment.



Another grieving mother, Patti, related to us the story of her son, Sal. Sal was born two months premature. His loved ones would later note that he came into this world early, and left early. Patti explained that Sal was an absolutely beautiful person with a heart of gold. He was a fiercely loyal, loving, sensitive young man who touched so many people during his life. Sal gave his family one of the most precious gifts that anyone could give - his beautiful son.

Sal was addicted to heroin. He also had no health insurance. One day, he reached out to his family for help. They took him to a hospital emergency room. The hospital turned him away and provided his parents with a list of treatment centers. They called every treatment center on the list and were turned away by all of them when told that Sal was using heroin. They were told that no beds were available, and that the situation was not life threatening. His parents came to learn that if they were to say that he was abusing alcohol, rather than heroin, he would have a better chance of getting into a treatment program. They proceeded to call one of the facilities that had previously turned them down. This time, they said that he was abusing alcohol. The treatment facility told them to call back first thing in the morning, explaining that there would be a bed available, along with funding. Sal called back at 8:00 in the morning and said that he was drinking alcohol and needed help. He was told to come right to the facility and that there was a bed available for him. His parents drove him to the treatment center, but only after making him drink vodka so that alcohol would be in his system. He was admitted for treatment and was told that the county would pay for his therapy.

Eleven days later, the facility called Sal's family to say that his funding had run out and that they had to come get him. Sal told them that he was afraid to leave because he needed more help. Sal's sister came to the treatment center to pick him up. She was told to take him directly to another facility. His release papers had a box checked that indicated a "high risk of relapse."

Sal's sister drove him directly to the other facility, but when they arrived, they were told that no beds were available. Sal and his family spent the day calling treatment centers. Despite his need for residential treatment, the only facility willing to take him provided only intensive outpatient therapy. This IOP program met only three days a week from 6:00-9:00 p.m. While in that program, Sal relapsed and suffered an overdose.

Sal was not alone at the time, but no one called 9-1-1 to seek medical assistance. Perhaps they were afraid of being arrested. As a result, Sal was left alone to die.

Our Task Force is grateful to all of the grieving parents who mustered the strength to share their painful and unexpected journey into the world of opiate addiction. As much as the testimony of the professional experts we invited to our public hearings, the bitter lessons learned by these courageous mothers and fathers informed our recommendations on how to address the myriad problems that confront our system for apportioning substance abuse treatment services. The heartfelt testimony of Chris's father Dominick (page 18), Patrick's mother Megan (page 17), Christian's mother Kass (page 32), Sal's mother Patti (page 33), Richie's mother Karen (page 49), and others exposed with penetrating candor the gaps and deficiencies in our current treatment practices and procedures.

Their real-world experiences underscore the urgent need:

- to set and enforce professional standards for treatment providers, and to establish continuing education requirements, so as to make certain that treatment services comport with evidence-based advances in the field of addictions science;
- to ensure that treatment services are carefully matched to the individualized clinical needs of patients in terms of the type, intensity, and duration of treatment, and are not driven by arbitrary, one-size-fits-all limits that are based on short-sighted financial considerations;
- to ensure that patients at a high risk of relapse or suicide are not discharged prematurely, or stepped down to clinically-inappropriate services; and
- to make certain that patients and their loved ones are fully and objectively informed about their treatment options, are afforded meaningful input in treatment decisions, and are provided complete and accurate information about the services that they actually need, based on validated assessment and placement criteria, and not just services that happen to be readily available.

Those are some of the guiding principles that inform our recommendations on how to enhance and improve access to addiction treatment in this State.

Of course, all of this presupposes that there are adequate treatment resources to meet the growing demand for rehabilitative services. Our Task Force is by no means the first in this State to urge expansion of our State's substance abuse treatment capacity.

As we add our voice to the chorus, it bears repeating that our focus in this report is on young people who are at risk of opiate addiction, or for whom that risk has already come to fruition. While we agree wholeheartedly that this State needs to expand all manner of substance abuse treatment services and opportunities, it is especially important to reserve sufficient resources to address the distinctive needs of adolescents and young adults who become opiate-dependent. In the juvenile justice context, there has been much research in recent years on the distinctive nature of the so-called "juvenile brain." This scientific research explains how the adolescent brain functions differently from an adult's brain when it comes to projecting future consequences, assessing risks, and making decisions. It is hardly surprising that modern science has confirmed a biological basis for a phenomenon that has been recognized for thousands of years: risk-taking is part of the normal adolescent experience, as is the instinct to resist authority. (That is why it is so important that we make certain that our public awareness messages are carefully designed to resonate

with young people, and not just with the adults who craft the anti-drug message.) It also appears that adolescents experience faster addiction cycles (the time elapsed from first use to drug dependency) than their more mature substance-abusing counterparts.

Experienced treatment providers know that adolescents are an especially difficult population to deal with. Indeed, some providers are reluctant to accept them. For this reason, we need to be certain that in developing a statewide plan to apportion expanded treatment services, adequate resources are set aside for young people.

As we join with others in calling for more treatment services, we believe we can best contribute to the conversation by candidly addressing some of the specific circumstances that impede expansion and that make it harder for persons in need to access clinically-appropriate treatment and aftercare services. We also take this opportunity to stress in the strongest possible terms that expansion of treatment capacity must not be done at the expense of quality control and licensing standards. Providing poor quality or inadequate treatment plays a cruel hoax on addicts and their loved ones. Inappropriate treatment – services that are not matched to the clinical needs of the patient based on accepted assessment and placement criteria – may in some ways be worse than a waiting list because it misleads patients and their loved ones into believing that their search for treatment is over.

We have noted throughout this report that the prescription drug and heroin abuse problem is at its core a *health care* crisis. While there are, of course, criminal law ramifications that must be handled by our law enforcement colleagues, we should not stray from a medical model. *Precisely because addiction is a disease, it needs to be treated with the same level of professional competence and evidence-based therapies as we demand and expect for the treatment of any other medical affliction.*

We would not tolerate, for example, an emergency room doctor who stabilizes a gunshot victim's vital signs only to discharge the patient without addressing the life-threatening internal damage caused by the bullet. Nor should we accept a substance abuse treatment system that focuses only on acute needs (e.g., reviving an overdose victim with an opiate-antidote, or detoxification) and ignores chronic ones. Administering a drug like naloxone to an unconscious addict is a critical step needed to save a life, but is not nearly enough by itself to accomplish that goal. So too, detoxification without follow-up treatment merely delays the inevitable, sometimes only briefly. Repeated episodes of detox followed by inadequate treatment, or no treatment at all make no sense, not only from a health care perspective, but also from an economic perspective. In Section 3.1.3, we discuss the concept of “parity” in the context of health insurance coverage. That concept starts by ensuring the quality of substance abuse and mental health treatment services with the same commitment that we make to ensure the quality of medical and surgical treatment services.

Given the persistent nature of addiction, relapses occur even when appropriate treatment is offered. We would all but guarantee that result, however, were we to provide inappropriate treatment in the guise of frugality. The point is simply that in our zeal to expand substance abuse treatment capacity, we must not compromise licensing standards for the sake of expediency or false economy.

Part 3.1.1

Finding Help to Find Treatment

As noted throughout this report, many families in this State confront the challenge of finding a substance abuse treatment program that can provide the appropriate type and level of care that is matched to the patient's clinical needs. Tough as that task may be, the quest does not end by identifying a treatment provider that has an open space. That bed or slot is not truly available unless it can be paid for.

Patients in crisis and their families are generally unfamiliar with the process for securing and then paying for treatment services. They need assistance not just in getting immediate help for a person in crisis, but also help in understanding how necessary treatment will be paid for under health insurance policies, laws, and regulations. They need to know what their rights are, and how to navigate a managed care system that can be bewildering to those who are not acquainted with its intricacies.

Just as New Jersey partners with the casino industry to help people with gambling problems connect to treatment and support services, we should look to the pharmaceutical industry as a partner in helping to connect addicted youth and their parents to the substance abuse and mental health treatment services they have been pleading for. There are a number of referral lines already operating in New Jersey that could take on these additional responsibilities were they to be provided additional resources. By way of example, the Mental Health Association of New Jersey currently has an information and referral line called NJMental Health Cares. This service line is staffed 7 days a week, 12 hours a day by bachelor and graduate degree-level behavioral health professionals who have been specially trained to assist in navigating the Division of Mental Health and Addictions Services system. The line has taken on disaster duties and suicide hotline responsibilities as the need has dictated. With additional training and funding, this line could be expanded to meaningfully assist those in need of addiction treatment services.

Action Step: GCADA should work with the pharmaceutical industry and other corporate citizens to create an informational “warmline” that offers real time information on how to gain treatment for opioid addiction, both inpatient and outpatient; that helps citizens to navigate the human services system; and that helps citizens understand and exercise their rights under a managed care system.

Part 3.1.2

Medication-Assisted Treatment (MAT)

Not all treatment professionals agree on the best methods and practices for treating addiction. For example, there is disagreement within the treatment community with respect to the efficacy of medication-assisted therapies, where FDA-approved medications such as buprenorphine, methadone and naltrexone are prescribed to stabilize patients and mitigate the symptoms of withdrawal.

There is also controversy in the 12-step recovery community concerning MAT, even though the long-held position of Alcoholics Anonymous General Service Agency is that persons in recovery should follow their doctors' orders, and Narcotics Anonymous takes no position on MAT. Some individuals in the 12-step recovery community nonetheless hold to the view that the commitment to abstinence precludes any use of

such medications. Those opinions thus appear to conflict with the official positions adopted by the national recovery support organizations.

One effect of this controversy within the treatment community has been to stigmatize medication-assisted therapy, making it unavailable for those who might benefit from it. As we have already noted, substance abuse treatment, like all forms of health care treatment, must be based on state-of-the-art science. It appears, however, that in many instances, the decision to forego MAT is based on what is essentially a philosophical predilection that is maintained by some without regard to clinical studies that reveal recent advances in addiction medicine. Some of those new research developments challenge orthodox views on how best to treat opiate dependence.

At one of our public hearings, we heard testimony from Dr. Louis Baxter, one of the Task Force members, who currently serves as President and Executive Medical Director of the Professional Assistance Program of New Jersey. Dr. Baxter previously served as the President of the American Society of Addiction Medicine. He explained that less than one-fifth of treatment facilities incorporate medications into their treatment regimen. He attributes this to the failure of the treatment community to keep pace with new developments in addiction research.

While our Task Force is reluctant to engage this scientific debate, we see problems with the two polar extremes in this controversy. Some treatment facilities apparently refuse even to consider the benefits of medication-assisted therapy. On the other side, some prescribers dispense these medications without ensuring that substance abuse treatment is provided. The former position may be ignoring the potential benefits of these medications as indicated in recent research. As is true for all aspects of the medical sciences, practitioners must stay abreast of ongoing developments in their field. The latter position, meanwhile, misconceives the fundamental nature of substance abuse treatment by failing to recognize that while detoxification and maintenance are sometimes needed to provide an opportunity for treatment to work; neither technique will do anything to change the patient's long-term use of other drugs. Medication-assisted treatment means just that: medications that are prescribed to assist the treatment process, not to be a substitute for treatment.

Action Step: GCADA should coordinate with the appropriate State agencies, such as the Division of Consumer Affairs and the Department of Health, along with the State's medical schools and the professional licensing boards representing substance abuse treatment professionals, to develop training materials and curricula to ensure that all treatment professionals understand the benefits and risks associated with the use of medications such as buprenorphine.

Part 3.1.3

“Parity” and Other Issues Concerning Health Insurance Coverage

Time and again during our public hearings, we heard from grieving family members about how desperately-needed treatment was delayed or denied because of questions concerning health insurance coverage. This is a major barrier to treatment that urgently needs to be addressed. It is also an exceedingly complex topic - one that must be considered in light of economic and fiscal realities. Even experts on the subject disagree on the inter-relationship between various federal and state laws. It is no surprise, then, that the entire process is

bewildering to lay people, especially those who are in crisis, which is why we recommended in Section 3.1.1 to establish a means to explain the insurance coverage system to those who need to rely on it.

One of the most important federal laws on the subject is known as the Paul Wellstone and Pete Domenici Health Parity and Addiction Equity Act of 2008. Among other things, this law provides that if an insurance provider offers insurance coverage for a mental health or substance abuse problem, it must be in “parity” with the coverage provided for other illnesses or injuries. In other words, the benefits for mental health and substance abuse treatment services must be comparable to the coverage provided for medical and surgical services. While the federal parity law expands coverage to many patients, it only applies to certain types of insurance plans – and only if coverage is offered for mental health and substance use.

The federal parity law must be read in the context of New Jersey’s statutory scheme. One State law codified at N.J.S.A. 17B:26-2.1s provides that insurance coverage for “biologically-based mental illness” must be under the same terms and conditions as provided for any other illness. The term “biologically-based illness” as defined in the statute, however, would not include substance abuse, post-traumatic stress disorder, or many emotional or behavioral disorders experienced by children and young adults.

Another New Jersey law codified at N.J.S.A. 17:48E-34 specifically concerns alcoholism treatment benefits. That law provides that health insurance policies must cover expenses incurred for alcoholism treatment provided at a licensed detoxification facility and for inpatient or outpatient care in a licensed treatment facility. There are, however, no similar statutory provisions concerning treatment for a drug addiction. (In many cases, it should be noted, drug addicts abuse several substances, including alcohol).

In July 2013, the New Jersey Senate Oversight Committee convened a three-hour hearing to discuss issues concerning insurance coverage and its impact on access to substance abuse treatment. One of the recurring themes at that hearing, as was true for our own public hearings, was that our current insurance system often encourages patients and health care providers to manipulate a diagnosis. It is ironic in this regard that substance abusing patients are motivated first to lie to their doctors so as to secure drugs and refills, and later to lie to treatment professionals to secure access to treatment. There has to be a better way to address these issues.

In August 2013, Governor Christie embraced a better approach when he announced an historic plan to create parity in mental health and substance abuse treatment benefits. In an effort to ensure that individuals who are battling mental illness and substance abuse are treated with the dignity and care they deserve, the Governor announced that the committee that determines health benefits for the more than 200,000 members of the School Employees Health Benefit Program had approved a plan to ensure that non-biologically-based illness will be treated in the same way as biologically-based illnesses. The enhanced coverage plan addresses the limits that have until now been placed on the coverage levels and number of days of treatment available on both an inpatient and outpatient basis for non-biologically-based mental illnesses. Under the new plan, those artificial limits will no longer apply, and all benefits for both biologically and non-biologically-based mental illnesses will be subject to medical necessity and physician review.

We believe that this approach recently announced by the Governor should serve as a model by which to achieve true parity for mental health care and addictions treatment that covers all conditions outlined in the Diagnostic and Statistical Manual of Mental Disorders and the American Society of Addiction Medicine’s Patient Placement Criteria.

State law also needs to clarify who decides the scope of treatment services that are to be paid for by insurance, the duration of such treatment services, and what criteria are used to make those decisions. Those parity-related questions are as important as the question whether addiction treatment expenses will be covered at all. In the case of physical disorders, health insurance covers the level of medical-surgical treatment that is needed to get the patient better, applying accepted medical standards. In the case of substance abuse treatment, health insurance should be required to cover the level of treatment that matches the clinical needs of the patient, applying validated assessment and placement criteria. That is the essence of true parity.

There are other cost-related issues that affect access to treatment and that need to be addressed besides the questions concerning parity between medical-surgical insurance coverage, coverage for mental health treatment, coverage for alcoholism treatment, and coverage for addiction treatment involving substances other than alcohol. In order ultimately to ensure unimpeded access to treatment, we need to establish adequate reimbursement rates for the services provided by community-based behavioral healthcare providers. These providers constitute the “safety net” that is needed for uninsured or under-insured addicts to make certain that they are not just turned away. When a commercial insurer denies visits or does not give prior authorization for treatment, or when patients simply use up their allotted coverage or do not have coverage, they come to the public community behavioral healthcare system for service at taxpayer expense.

The State is moving toward a managed care model under Comprehensive Medicaid Waiver. To that end, it has engaged a consultant to set rates for mental health and substance use services. Those rates will have to be adequate to cover the cost of care that is needed, considering patient-specific clinical needs and the need to maintain quality standards for all substance abuse treatment services.

Action Step: GCADA should work with lawmakers, such as the members of the Senate Oversight Committee, to facilitate meaningful discussions about insurance practices that create barriers to mental health and substance abuse treatment.

Part 3.1.4

Addressing the “NIMBY” Barrier to Expanding Treatment Capacity

Expanding the capacity of treatment programs is not merely a question of finding more dollars to dedicate to treatment services, which is hard enough in tough fiscal times. There are also “siting” questions that need to be resolved. There are “bricks and mortar” limits on the expansion of capacity at existing treatment facilities, especially those that offer residential treatment. This means that new facilities and campuses will have to be built to accommodate the demand. Where will these new treatment facilities be located?

The simplest answer would be to say that new facilities should be conveniently accessible to the people who will be using them. The siting issue becomes far more complicated, however, because, as noted throughout this report, the increase in the prevalence of prescription abuse and resultant heroin abuse is by no means restricted to urban centers, where detox centers and treatment facilities have traditionally been clustered. To the contrary, the new breed of opiate abuser is just as likely, if not more likely, to live and work in suburban and rural areas.

This circumstance raises the specter of the so-called “Not in My Backyard” (NIMBY) syndrome. Some people who *conceptually* support the need to expand treatment capacity balk at the notion of having a treatment facility open in their own neighborhood. Many citizens fear that these facilities will attract drugs or violence, and lower property values.

Some of those concerns can be addressed as one part of the comprehensive public awareness campaign regarding the entire prescription pill and heroin abuse problem that we recommend in Section 3.2. One of the important messages we need to send to homeowners in suburbia, after all, is that the drug problem already exists in their backyard. Heroin addicts already live, and die, in their neighborhoods. Prescription drug and heroin abusers are already driving – whether sober or under the influence – on local streets where children are playing. If the point of their objection is to keep opiate abusers out of their neighborhood, they are too late. They are already there.

Some citizens have begun to use zoning laws and ordinances to block treatment expansion, or at least to make the construction of new treatment facilities cost-prohibitive through the threat of protracted land use litigation. These legal issues need to be carefully studied and debated. Because there are so many different stakeholders, it is not feasible for our Task Force to hear all sides of the issue at one of our public hearings. The simple truth is that while concerned homeowners may flock to a local zoning board hearing to voice their objection to construction of a specific treatment facility in their town, those site-specific advocates would not be likely to attend any public hearing that our Task Force might convene to address more generally the need in this State for improved access to treatment services. We therefore believe that it is for lawmakers to examine the issue and to determine whether they had intended for zoning and land use laws to be used to decide the allocation of accessible treatment services, or whether there might be a better way to assess local and regional treatment needs so as to assure accessibility.

Action Step: GCADA should coordinate with lawmakers on addressing the practice of using land use statutes and ordinances to impede the construction of new substance abuse treatment facilities that are needed to service the addiction treatment needs of local residents.

Part 3.1.5

Access to Treatment in County Jails

By some estimates, upwards of 70% of the persons in jails or prisons are addicts or alcoholics in need of treatment. The National Center on Addiction and Substance Abuse at Columbia University (CASA), issued an authoritative report entitled “Behind Bars II” that documents the efficacy of treatment within incarcerated settings, provided that treatment is continued upon release. There has been progress in recent years in recognizing the need to provide licensed, clinically-appropriate treatment to state prison inmates who suffer from an addiction or a mental illness. It has been brought to our attention that in most county jails, as distinct from state prison facilities, substance abuse treatment services are not provided. We are told that the Hudson and Middlesex County correctional facilities are notable exceptions.

County jail populations are comprised of two types of individuals: persons charged with indictable crimes (*i.e.* felonies) who are unable to make bail while awaiting trial, and persons who have been convicted of comparatively minor offenses (known as “disorderly persons” offenses in New Jersey jargon, but more

commonly known around the nation as “misdemeanors”) and serving sentences that are less than one year, and often only a few months or less.

At the very least, this period of incarceration would seem to provide an opportunity to determine whether an inmate is drug or alcohol dependent and in need of treatment services. As we have noted throughout this report, denial is an all-too-common symptom of the disease of addiction, and many addicted defendants may choose to conceal their problem from correctional authorities and judges. We understand that corrections officials, of necessity, undertake a sophisticated process of intake and classification to ensure, for example, that a defendant associated with a particular street gang is not housed with members of a rival gang. It would seem that this intake and classification process should include a professional diagnostic assessment to determine whether the person has a drug or alcohol problem that needs to be addressed to stop the cycle of addiction and crime.

We recognize that there are many complex issues that need to be considered before we could make specific recommendations on providing treatment services to county jail inmates. Because we did not address these issues at our public hearings, it would be appropriate for our Task Force to conduct further fact-finding and to solicit input from all of the stakeholders.

Action Step: GCADA should authorize the Task Force to hold a hearing to discuss the effectiveness of, as well as the policy and practical challenges in providing substance abuse and mental health diagnostic and treatment services to county jail inmates, using existing programs as models.

Part 3.2

Educating the Public

We began our discussion of how to address the “enabling” circumstances identified in Section 2.4 with a discussion about the barriers to treatment out of respect for the many parents who came before us to tell their tragic stories. As we have noted repeatedly in this report, nothing is more important than the steps that are urgently needed to obviate the need for treatment. We now turn to those critical prevention and deterrence initiatives.

If we are to stem the tide of the new epidemic, citizens in all walks of life must be alerted to the problem, and armed with information that will allow them to recognize when they and their loved ones are at risk. We must do more, however, than spread information. We must change cultural attitudes about prescription drug abuse and diversion. To begin this process, we urge the State to develop a comprehensive and carefully coordinated public awareness campaign that takes advantage of every type of media, including print, billboard, television and radio ads and public service announcements, as well as messages on non-traditional media, such as milk cartons and water bottles. This awareness campaign should also take full advantage of the internet and “social media” to spread the word about the dangers of this particular form of substance abuse.

Part 3.2.1

The Need for a Sophisticated Campaign Strategy

This public awareness initiative will require an extremely high level of sophistication. It requires not just a multimedia delivery system, but also multiple themes targeted at different audiences. We will also need to stigmatize prescription drug abuse and diversion while recognizing the legitimate use of those same drugs as medications. Unlike heroin, it is the *abuse* of these medications, not the medications themselves, which we must target for societal condemnation.

One of the unintended consequences of our decades-old policy to demonize “street drugs” such as heroin is that it strengthens denial among prescription drug users (“I may use pills, but I will never try *that* drug”). Today, of course, we know that the distinction between prescription medicines and “street drugs” has been blurred. Diversion makes prescription drugs available on the streets through the black market. As we have already noted, many criminal street gangs and other “traditional” drug trafficking organizations (as distinct from “pill mills” that may at least try to create the illusion of being a legitimate health care provider) today stock a wide assortment of controlled substances, including illegally-diverted prescription drugs. The point, however, is that the message we need to send is not nearly as simple as declaring that these controlled dangerous substances are inherently bad and must be avoided. For prescription drugs, the message is more sophisticated because we cannot simply promote abstinence.

It is especially important that we rebut commonly accepted myths about substance abuse and abusers, including the stereotype of the heroin user as a back alley denizen. We must show the new face of the opiate abuser and explain the new pathway that leads so many young people to heroin abuse. We must, in other words, explain the reasons *why* people abuse prescription medications, and why those abusers turn to heroin. We need to inform the public as to the red flags of opiate abuse, and educate them not only to know when help is needed, but also how to get that help.

In short, we will need to develop several complementary messages that are tailored for various target audiences. No single tag line will influence all of them. We need a message that resonates with those who are personally at risk of prescription drug abuse, or have already started down that pathway. We also need a message for others – parents, friends, teachers, school nurses, and employers, among many others – on how to recognize the warning signs of painkiller abuse, and on how to safeguard homes by, for example, properly disposing unneeded medications.

We need to publicize the enlightened features of the Overdose Prevention Act so that if an overdose crisis should arise, a call for medical assistance will not be chilled or delayed by fear of arrest and prosecution for drug possession. As was explained in our discussion of treatment interventions, we must publicize the various hotlines and “warmlines” for reporting abuse and for getting help.

It bears repeating that as part of a comprehensive prevention strategy, we must do more than educate the public on how to recognize and respond to opiate abuse. We must educate the public on the steps that people can take to prevent and deter family members, friends, students, patients, co-workers, colleagues, and others from first experimenting with inappropriately obtained prescription pills, and from misusing medications that have been lawfully prescribed.

We recommend that GCADA conduct focus groups and a household survey to gauge the effectiveness of the prevention, education, and public awareness campaign. This will allow the messages and delivery media to be refined as needed so as to have the greatest positive impact on the various target audiences.

Action Step: GCADA should work with other prevention stakeholders, including the Division of Mental Health and Addiction Services, the United States Drug Enforcement Administration, and the Partnership for a Drug-Free New Jersey, to coordinate the development of a comprehensive multimedia and multicultural public awareness campaign. This public awareness initiative should become a public-private partnership involving the pharmaceutical and health care insurance industries. GCADA should monitor the impact of the comprehensive public awareness campaign, and refine it as needed.

Part 3.2.2

Important Themes and Messages

Our Task Force must, of course, leave to our partners and stakeholders the job of designing the actual themes and messages in this multimedia campaign. We nonetheless take this opportunity to suggest that a comprehensive public awareness campaign include the following points besides describing the exponential increase in opiate abuse and the surprising new face of today's young opiate addict:

- Patients should be urged to ask their doctors for treatment, and not necessarily a pain pill.
- The public needs to understand that substance abuse treatment works, and that relapses occur not because treatment is ineffective, but rather because of the nature of addiction, which is a chronic relapsing disorder. Those who successfully overcame a nicotine addiction only after repeated attempts to quit smoking will certainly understand the truth in that message.
- While the public has cause to be alarmed, they also need to be given hope by hearing about success stories where lives were reclaimed, and not just hear about lives that were lost.
- We need to de-stigmatize the treatment process, including medication-assisted therapies that incorporate the use of drugs such as methadone and buprenorphine.
- Citizens who oppose treatment being provided in their neighborhoods must come to realize that the negative effects of substance abuse and addiction are already there.
- Citizens must understand the provisions of the Overdose Prevention Act, which gives immunity to persons who call for medical assistance when an overdose occurs, and makes it easier to obtain and keep opiate antidotes to be used in the event of an overdose.
- Citizens must know where to turn for help in finding, and paying for, substance abuse treatment services.
- Citizens must know about the linkage between opiate abuse and suicidal behavior.

Part 3.3

Coordinating the Contributions of Schools and Colleges

If you want to influence the attitudes and behavior of young people, you need to go to the places where young people congregate. It is vitally important that middle schools, high schools, community colleges, four-year colleges, and universities be enlisted in our State's strategic plan to address prescription drug abuse.

Part 3.3.1

Updating Alcohol and Drug-Related Curricula

Current regulations promulgated by the State Board of Education require that all schools present a curriculum designed to prevent children from abusing chemical substances and alcohol. We need to be certain that the core curricula standards are up-to-date and account for the misuse of the prescription drugs that today are often found in parents' and grandparents' medicine cabinets.

Given the fast pace at which the substance abuse culture is changing, by the time a curriculum is adopted by local school districts and introduced in the classroom, it may already be out-of-date. Changes in these curricula cannot wait for policymakers to compile and analyze information supplied by the State Medical Examiner and emergency room physicians. The basis for that information about changing substance abuse patterns – overdoses and deaths – comes much too late. For this reason, the GCADA Task Force should help to develop updates to curricula that schools can use as soon as possible, and at little or no cost. Our Task Force should also work with educators, student assistance counselors (SACs), school resource officers (SROs), DARE officers, and Municipal Alliances to be certain that the messages that are communicated by schools reflect what is happening today in households all across the State.

We cannot overstate the importance of educating children about the dangers of prescription drug abuse. The curriculum must not only include updated information about this new path to drug addiction, but it must be carefully crafted to reach a wide target audience to include pre-teens through young adults. It is a responsibility that we, the Task Force, believe in so strongly, that we propose that the Task Force oversee the curriculum development and implementation process.

Action Step: GCADA should authorize the Task Force – in partnership with stakeholders such as the Department of Education, student assistance counselors, school resource officers, DARE officers, Municipal Alliances, and educators – to coordinate and oversee the effort in updating core curricula standards pertaining to substance abuse and in developing and disseminating updated curricula that address the problem of prescription drug abuse.

Part 3.3.2

Peer-to-Peer Programs

Young people can be skeptical of the messages that are developed and delivered by adults. The credibility of the spokesperson can be as important if not more important than the message itself. Sometimes, moreover, a message that seems to be clever and effective to adults simply misses the mark from the perspective of adolescents.

Experience has shown that youth mentors and leaders can have a profound influence on their peers – for good or for ill. We need to enlist and empower peer leaders to help communicate accurate information about the opiate abuse problem, and what to do when a friend displays the telltale indicators of prescription drug abuse, or appears to be experiencing an overdose.

While our focus in this report remains on adolescents and young adults, it bears noting that these kinds of school-based programs need not be restricted to the grade levels where children are most likely to be experimenting with prescription drugs. Even children in lower grades can be enlisted to support the cause by, for example, encouraging their parents and grandparents to properly dispose of unused prescription drugs. For many years, young children have been used as allies to encourage parents to take household fire safety precautions, such as installing and maintaining smoke and carbon monoxide detectors. These family projects provide an excellent forum for parents to talk to their children about safety issues, and to plan, for example, what to do in the event of a fire emergency. Very young children can also urge their parents to keep medicine cabinets safe from being raided by older siblings and their friends who are looking for mind- or mood-altering drugs.

Action Step: As a component to the effort to update and disseminate school curricula addressing the problem of opiate abuse, GCADA should work with stakeholders, like the Department of Education, to develop and promote peer education and leadership programs – or take advantage of existing programs as appropriate – to design and communicate effective messages to middle school and high school students about the dangers of prescription drug abuse. Similar peer programs should also be developed in colleges and universities across the State.

Part 3.3.3

Recognition Training and Reporting Procedures for School Staff and Administrators

In the late 1980's, in direct response to the crack epidemic in the New York/New Jersey region, the Attorney General in conjunction with the Commissioner of Education formed an Education and Law Enforcement Working Group, which includes representatives from all aspects of both the education and law enforcement professions. That group developed a Uniform Memorandum of Agreement between Education and Law Enforcement Officials that explains in detail how educators, police, and prosecutors will work together to keep schools and school-aged children safe from illicit drugs.

That MOA, which all school districts are required to sign pursuant to regulations promulgated by the State Board of Education, has periodically been revised by the Working Group to address new problems as they arose. For example, the agreement has been updated over the years to deal with bias crimes, bullying, guns and violence in and around schools, and the abuse of anabolic steroids. To ensure that the MOA is properly implemented, the agreement requires annual “roundtable” meetings of local school superintendents, police chiefs, and county prosecutors. This has become an important forum in which to discuss new trends and new dangers that children and all members of the school community need to be aware of and on the lookout for.

As a direct result of the earlier drug epidemic involving “crack” cocaine and, later, steroid abuse by adolescents, New Jersey already has in place an impressive and collaborative infrastructure through which to share information and ideas about the constantly-evolving substance abuse problem. We urge the Attorney General and Education Commissioner to make full use of that platform to address the current epidemic of prescription drug abuse. It is especially important that all teachers, coaches, administrators, school nurses, guidance counselors, child study team members, and school custodial staff receive in-service training on the telltale indicators of prescription drug abuse, and follow the procedures for reporting suspected abuse to school administrators so as to ensure immediate medical examinations and interventions that respect students’ privacy and confidentiality rights.

Action Step: GCADA should explore with the Attorney General and the Commissioner of Education re-convening the Attorney General’s Education and Law Enforcement Working Group, in order to draft appropriate revisions to the Uniform State Memorandum of Agreement between Education and Law Enforcement Officials and address the problem of prescription drug abuse by or affecting schoolchildren. All school staff members should receive training on prescription drug abuse reporting protocols, and on how to recognize the warning signs of such abuse.

Part 3.3.4

Recovery High Schools

Even in the best of circumstances, drug rehab is not easy. It is even more difficult when adolescent addicts must also endure the normal stresses associated with school. In 2004-2005, 37,790 New Jersey students were referred to a school-based program or outside service for reasons related to the use of alcohol or other drugs (excluding smoking cessation). Studies indicate that the prognosis for students who complete a treatment program is poor, with relapse rates as high as 85% upon returning to school.

The problem lies not in the quality of the treatment services that were offered, but rather in the nature of the environment that school-aged recovering addicts must return to. According to Dr. Dale Klatzer, President and CEO of the Providence Center – a community behavioral health organization in Providence, Rhode Island – 93% of students who return to their high school are offered substances on their very first day back at school. Dr. Klatzer also reported that within 90 days of returning to school, 50% of the students who have gone through treatment are using substances at levels at or above where they were prior to treatment. Most of those who relapsed did so within the first month out of treatment.

There is a growing body of evidence that relapse rates can be greatly reduced if recovering students had the opportunity to attend a “recovery school” – a small supportive community that fosters an environment within which these students feel safe. At such institutions, students would not be stigmatized by their addiction. They would not be outcasts, and they would not be pressured by other students to return to active substance abuse. To the contrary, the conclave of students sharing the experience of recovery would become a natural support group, encouraging sobriety.

Thomas Kochanek, a Rhode Island college professor, conducted a study of the three recovery high schools in Massachusetts. He found that after five years, 80% of the students had maintained a commitment to their recovery and that a majority of students earned a B average or higher. Twenty months after graduation, 90% of the students were either enrolled in college or were employed.

Despite the research that shows the potential effectiveness of recovery schools, past efforts in New Jersey to replicate this model have not been successful. Notably, those who have attempted to start a recovery school have run into legal problems in trying to fit the recovery school model into our statutory and regulatory framework for “charter schools.” Those efforts were also met with skepticism by officials who questioned the need for such educational programs. As noted throughout this report, denial of a substance abuse problem can paralyze many things, including the incentive to innovate.

Given the exponential increase in prescription drug abuse, we believe that local authorities can no longer deny the dimension of the problem and the need for action. At the very least, the idea of establishing a pilot recovery school in this State is worth discussing, not just to save lives, but also to conserve resources and save taxpayer dollars. If the successful institutions in Massachusetts could be replicated here, we could reduce the strain on the juvenile justice system, cut down on the cost of repeated treatment, and increase high school graduation rates.

Action Step: GCADA should convene a meeting of stakeholders to consider the benefits and impediments to establishing a regional recovery school as a pilot demonstration project. The stakeholders should consider statutory and/or regulatory changes that might be needed to remove barriers that effectively prevent those in this state from replicating educational programs proven to be successful in other jurisdictions.

Part 3.3.5

Recovery Programs and Services in Colleges

College students who have been diagnosed with alcohol and/or drug dependence are more likely to have academic problems, legal problems, health problems, housing problems, interpersonal conflicts, and financial problems. They also have higher rates of injury, drunk or drugged driving, unsafe sex, and sexual abuse. About 20% of the college freshmen who drop out do so because of their substance abuse problems.

Many colleges in New Jersey have some kind of substance abuse prevention program. Fewer schools - and few if any community colleges - provide support services for recovering students. These services might include individual counseling, group counseling, and availability of 12-step meetings, alumni recovery contacts, activities for students in recovery, academic support, psychiatric services, and recovery housing. It

is important that those services be offered to college students who are in need of them. The lack of access to affordable treatment, which we addressed in Section 3.1 of this report, may be particularly acute when the substance abuse problem arises or worsens at college, since the student is more likely to be away from home and family.



Karen, a Pennsylvania resident, came to one of our hearings to share the story of her son, Richie, who died of an accidental overdose at the age of 21 while away at college. Richie was a warm, compassionate young man noted for his wonderful sense of humor and infectious laugh. His parents beamed with pride on the day they drove him to college his freshman year, and were devastated three years later when they brought him home for burial.

As a teen, Richie began to use marijuana and alcohol, but concealed it from his parents. In his sophomore year in college, he came home for the winter recess and finally told them he had a problem and needed their help. They got him into treatment and after four months, he felt that he was ready to return to school. For a year, things were fine and he made Dean's List.

On July 1, 2003, at 2:00 in the morning, Richie's parents were awakened by a knock at the door. Two deputies told them there was a problem and that they needed to contact the sheriff's office in the out-of-state jurisdiction where Richie attended college. Karen explained to us: "From the short walk from our front door to where the phone was, I can remember thinking, Dear God, please let him be in jail. Can you imagine wishing your child was in jail? The deputies made the call. They hung up the phone and they told us that our son was dead. My husband and I screamed, crashed to the floor in a fetal position. I can remember hanging onto the deputy's leg, begging him to tell me our son was okay."

Richie had died from a combination of heroin, cocaine, alcohol and prescription drugs. Only later did Karen learn that he had also overdosed a month before he died. On that occasion, his friends had called for an ambulance, and he was revived from unconsciousness at the hospital by an opioid antidote. He was released from the hospital three hours after the 9-1-1 call that on that occasion had saved his life. At the time, he was seeing a psychologist for depression. That doctor was never told of the overdose; nor was his parents. His privacy rights under the law were dutifully respected, and in consequence, he was allowed to face the challenges of his depression and substance abuse relapse all alone.

Our Task Force may not be able to do much to convince colleges in other States to enhance the treatment and support services that they provide to drug or alcohol dependent students. But there are things that we can do in this State, working in partnership with New Jersey's colleges and universities. We can also take steps to alert parents of the need to inquire about the prevention, treatment, and recovery support services that are available to their children who are attending college in other States.

While we encourage all colleges and universities in New Jersey to provide a full spectrum of intervention services, it is especially noteworthy that recovery housing has been shown to be effective in helping recovering addicts avoid relapse. Students who are in recovery from substance dependence and who live in regular on-campus housing have only a 20% chance of remaining sober while at school. As we noted above in Section 2.6.6, when recovering students live in housing with other students who are in recovery, that number jumps to 80% , and at Rutgers, climbs to 95%.

Action Step: GCADA should convene a summit of officials from state and private colleges and universities, to discuss and evaluate their substance abuse programs and to encourage all schools to provide a broad spectrum of recovery support services, including recovery housing. Experts from out-of-state colleges that have developed exemplary programs should also be invited to share their experience and perspective. GCADA should also develop a campaign to convince parents of college students to inquire about the substance abuse prevention, treatment, and recovery support services that are offered by colleges in New Jersey and in other states.

Part 3.4

Using State-of-the Art Technology to Detect and Deter Prescription Drug Abuse: Making Full Use of the New Jersey Prescription Monitoring Program (NJPMP)

As we noted in section 2.6.4, New Jersey recently established a computerized Prescription Monitoring Program (NJPMP) that can serve as an important tool to detect and deter prescription drug abuse and fraud. As with all tools, the quality of the final product will largely depend on the skill and craftsmanship with which the tool is used. We have already spelled out in some detail how the NJPMP can be used to prevent prescription abuse in the first instance, and failing that, to detect abuse before a patient reaches a higher level of addiction severity. As explained earlier, the NJPMP can also be used as a tool to ferret out diversion by unscrupulous licensed professionals, both prescribers and dispensers. These are excellent features, but there is need for improvement.

Part 3.4.1

Compulsory Registration and Use of NJPMP

At present, registration and use of the NJPMP is voluntary. Current law does not mandate that healthcare practitioners or pharmacists sign up for access to the NJPMP. Nor does it require registered practitioners to consult the database prior to prescribing or dispensing a controlled dangerous substance, including opiates and other painkilling medications. Although the Division of Consumer Affairs, which administers the NJPMP, vigorously continues to encourage prescribers and pharmacists to sign up for and use the program, only a small percentage of eligible licensees have registered – less than 18% as of February 2014. For a program whose utility is measured in large part by the number of healthcare professionals who use it, the NJPMP is falling far short of its potential. Those professionals who prescribe and dispense dangerously addictive painkillers and antidepressants, especially for long term use, should be required not only to register, but also to make full use of this monitoring tool – an approach embraced more and more by states with PMPs.

Currently, 48 states use PMPs. Of those, 13 require mandatory registration for prescribers and, in some instances, for dispensers. At least 16 states identify circumstances when prescribers, and sometimes dispensers, are mandated to access the PMP (e.g., when prescribing or dispensing certain controlled substances that are especially prone to abuse). The clear national trend is not just to create a state PMP, but also to require prescribers and dispensers to register with and actually use these computerized information-sharing systems to help curb prescription abuse and diversion.

One obvious problem with a voluntary system is that it produces a self-selection bias. Prescribers and dispensers who are already concerned about the prescription abuse problem will tend to register and take advantage of NJPMP. Those, in contrast, who are either unaware of the nature and scope of the prescription abuse problem, or who otherwise are not particularly concerned by it, will tend not to participate. Ironically then, some of the professionals who are most in need of the tools that the NJPMP offers – physicians and pharmacists who prescribe painkillers without appreciating the risks and taking steps to control those risks – will tend not to avail themselves of the NJPMP's monitoring services.

While we urge lawmakers to mandate NJPMP registration and use for those professionals who prescribe and dispense dangerously addictive painkillers, we recognize the value in using carrots as well as sticks to change the culture of the medical professional to embrace this new technology. One way to incentivize full use might be to develop software that, consistent with all applicable privacy requirements, allows NJPMP to populate medical charts with the patient's complete prescription history so that this information would always be readily available as part of the office's electronic health records. Such software would obviate the need to invest staff time back-loading and constantly updating these electronic records. Recognizing that the proper use of NJPMP data will reduce a physician's or pharmacist's malpractice liability exposure, the insurance industry and managed care providers might also provide practical incentives by offering a discount on premiums or some other bonus to professionals who use the database.

Action Step: GCADA should promote a legislative initiative to amend the current law establishing the NJPMP to require prescribers and dispenser to register with and use the NJPMP before prescribing or dispensing those controlled dangerous substances with a high risk of abuse.

Part 3.4.2

Wider Access to NJPMP Data by Licensed Mental Health and Substance Abuse Treatment Professionals

There are other weaknesses in the current NJPMP system besides lack of registration and use by prescribing and dispensing professionals. Current law does not allow non-prescribing mental health providers, such as psychologists and social workers, to access the NJPMP database. The prescription drug history of a patient can be critical to the mental health specialist who is assessing the nature and extent of the patient's addiction.

Regrettably but predictably, a patient who is abusing prescription pills may not candidly provide his or her medication history to the mental health specialist, particularly at the initial evaluation or point of intervention. Access to the NJPMP, done in conformance with all applicable privacy requirements, would provide the treating mental health professional with the ability to verify and track the patient's prescription drug history, allowing for a more fully informed and effective regimen of mental health care and addiction treatment.

Action Step: GCADA should promote a legislative initiative to amend the current law establishing the NJPMP to expand NJPMP access to licensed mental health professionals involved in the diagnosis and treatment of substance abuse.

Part 3.4.3

Interstate Sharing of PMP Data

New Jersey is not an island unto itself. Those who abuse or illegally divert prescription drugs in a state with strong policies can get their drugs simply by traveling to another state. That is especially true in New Jersey because so many of our residents live or work in close proximity to New York, Pennsylvania, or Delaware. We commend the Division of Consumer Affairs for recognizing this reality and taking steps to enter into PMP data-sharing compacts with other states. New Jersey has already entered into such an agreement with Connecticut.

New Jersey needs now to be part of a nationwide communications exchange platform for tracking abuse and diversion. The National Association of Boards of Pharmacy has established such a platform – the NABP PMP InterConnect – which allows participating state PMPs across the United States to be linked and securely share data across state lines. Twenty-four states currently participate in the NABP PMP InterConnect project, with at least two more states expected to be sharing data by the end of this year. In order to detect “doctor shoppers” from crossing state lines to obtain drugs, and to better identify patients with prescription drug abuse and misuse problems, we urge NJPMP to join the NABP information-sharing platform.

Action Step: GCADA should coordinate with the Division of Consumer Affairs in its efforts to link the NJPMP with the NABP InterConnect as soon as possible to better detect prescription drug abuse and diversion across state lines. The Division should also continue entering into PMP information-sharing compacts with those states in the New Jersey region.

Part 3.4.4

Real-time Reporting of Prescription Data

As of March 1, 2014, pharmacies are required to upload prescription information to NJPMP once per week. Accordingly, when prescribers, pharmacists, or law enforcement officers are accessing the NJPMP prescription histories of someone for indicators of opiate abuse or criminal diversion, the data available will not be up-to-date and could be as much as 7 days old. In other words, the information has a significant likelihood of not only being incomplete, but also from both an intervention and investigative perspective, being relatively stale.

There is no question that were the State to require more frequent reporting of prescription information from pharmacies, the NJPMP would be a more useful and reliable tool for timely detecting abuse and diversion. The Task Force recognizes that real-time reporting will require a new level of commitment from pharmacies, one that likely will most impact the smaller, independent pharmacies that may be limited in their ability to dedicate the labor or acquire the technology required for uploading information as prescriptions are filled. We are sensitive to those concerns. Even so, given the seriousness of the opiate abuse and diversion problem, we believe real-time reporting is called for. And we're not the only ones. New York and Oklahoma already require pharmacies to report prescription information to their PMPs in real-time, while at least six other states mandate pharmacies to report updated information every 24 hours.

Action Step: GCADA should advance a legislative initiative to amend the current law establishing the NJPMP to require that pharmacies provide real-time prescription information to NJPMP, as the prescription is filled or at least within 24 hours.

Part 3.4.5

Electronic Prescription Script

Besides enhancing NJPMP, New Jersey needs to examine its technology for the issuing of prescriptions. As we noted in Section 2.6.2, substantial strides are being made in modernizing the security features of New Jersey prescription blanks – the printed pads that are used to record prescription orders. Despite those efforts, so long as those prescription orders are print- and paper- based, industrious forgers and counterfeiters will find ways to defeat the safeguards.

Electronic scripts are more secure. Sent directly from prescriber to dispenser over a secure electronic network, electronic scripts substantially reduce, if not completely eliminate, the opportunity for drug seekers to alter the prescriber's order. The systems could be linked directly to the NJPMP making it easier for prescribers to check for harmful drug interactions at the point of care. Furthermore, because there is no handwriting for the pharmacist to interpret, there is less potential for medication dispensing errors. This should eventually translate to lower health care costs. For all these reasons, New Jersey should explore the benefits, feasibility, and costs of updating to electronic scripts.

Action Step: GCADA should collaborate with the Division of Consumer Affairs, in partnership with stakeholders from the insurance industry, managed care providers, and licensed professions involved in prescribing and dispensing, to undertake a study to determine the feasibility of moving toward electronic scripts.

Part 3.5

Prescribing Standards and Best Practices for Prescribers

In Section 2.6.3, we lauded a recent initiative by the Division of Consumer Affairs and the State Board of Pharmacy to develop a set of best practices for the secure handling and dispensing of prescription drugs by pharmacists. That recent effort to promulgate pharmacy security best practices demonstrates that when regulators and licensed healthcare professionals work collaboratively, the end product is a modern, sensible regulatory blueprint that properly addresses the dangers associated with prescription opiates. We now need to build upon that model by developing best practices for all healthcare practitioners who prescribe prescription painkillers.

Part 3.5.1

Setting the Bar High

Physicians and other prescribers, including psychiatrists, dentists, nurses, and physician assistants, need to acknowledge their role in the current proliferation of prescription drug misuse, and must commit to be part of the solution. While the vast majority of healthcare practitioners exercise their prescribing authority sensibly and responsibly, undeniably some do not. And there is an increasing need for all prescribers to better understand the dangers of pain medication and the serious consequences of indiscriminate or over prescribing. Like the State's pharmacists, New Jersey's prescribers should engage a collaborative, cross-disciplinary effort to identify the very best standards for safely and responsibly prescribing opiates and other drugs having a high risk of abuse.

Healthcare boards will have an important role in this effort. Along with their licensed professionals, the boards should reexamine current regulations that govern standards of care to determine whether those standards ensure to the greatest extent possible that practitioners are maintaining effective controls against prescription drug diversion and abuse. By way of example, registration in the NJPMP, along with regularly consulting the database to review a patient's CDS prescription history, should become standard pain-management practice. The boards should also develop clear standards for determining appropriate dosing of pain medications, especially when prescribed for long term use. Standards also should be developed on when and how often blood and/or urine screens should be conducted when long-term painkillers are employed, and pain managers should adopt agreements with patients who are receiving pain medications that explain their rights and obligations with a view toward minimizing the risk of abuse. In fact, we would like to see actual sample contracts made available to practitioners as an appendix to the appropriate regulations (Appendix G).

The current Board of Medical Examiners regulation, N.J.A.C. 13:35-7.6 closely tracks the model advanced by the Federation of State Boards of Medical Examiners. Other healthcare boards should review similar models. All these boards, together with the Director of the Division of Consumer Affairs who has responsibility for registering all prescribers of controlled dangerous substances, should comprehensively assess practice standards for the prescribing professions, and implement critical safeguards against diversion and misuse.

Action Step: GCADA should coordinate with the Division of Consumer Affairs in convening a committee to review professional standards and establish best practices for managing pain and preventing diversion and abuse of prescription medications. The committee should be cross-disciplinary, consisting of representatives from the State Board of Medical Examiners and other licensing boards.

Part 3.5.2

Staying Abreast of Developments in the Field through Continuing Education

Setting professional standards is only one step in the process of ensuring the best possible quality of care while guarding against prescription abuse and diversion. We also need to make certain that health care professionals know how to apply and satisfy those standards. For example, all those who undertake to provide medical care to patients with chronic pain should be alert to red flags that indicate possible diversion. It almost goes without saying that doctors who prescribe painkillers must be fully aware of the risks and benefits of these drugs. The information they rely upon in making prescribing decisions should not just come from pharmaceutical reps whose job is to sell a product, but rather should also come from evidence-based continuing education programs.

In addition, all practitioners who prescribe painkilling medication should know how to discuss pain treatment options, including ones that do not involve prescription drugs; should prescribe only the quantity needed based on an appropriate pain diagnosis; and should be able to recognize the effects of drug interactions and avoid combinations of prescription painkillers unless there is a specific medical indication. These professionals should also be fully versed in identifying the need for substance abuse treatment, and should be familiar with appropriate treatment regimens, including evidence-based approaches and medication-assisted therapies. Professionals who prescribe pain medications should not only be able to recognize when treatment intervention is needed, but should know how to refer patients to treatment, recognizing that given the practical barriers to accessible and affordable treatment (which we discussed in Section 3.1), this process is not nearly as simple as handing a patient a referral letter to take to a specialist.

To these ends, the State Board of Medical Examiners and other healthcare boards overseeing licensed prescribers should make certain that their continuing education mandates are tailored to assure that practitioners treating addictions and managing pain stay current with developments in the field. Similarly, those boards and committees that oversee mental health professionals who provide counseling and other addiction therapy should take steps to ensure that their licensees are also trained in the latest approaches. Boards should consider partnering with New Jersey medical schools to develop continuing education programs addressing these issues.

Action Step: GCADA should enlist the proposed committee to review professional standards and establish best practices for managing pain and preventing prescription drug abuse and diversion, to work in partnership with the State's medical schools to establish a continuing education program that ensures prescribers and other addiction treatment professionals possess the most current information on pain management, opiate abuse, suicide prevention, and addiction treatment.

Part 4

Synopsis of Recommendations

3.1 Enhancing Access to Quality, Clinically-Appropriate Treatment

3.1.1 Finding Help to Find Treatment

Action Step: *GCADA should work with the pharmaceutical industry and other corporate citizens to create an informational “warmline” that offers real time information on how to gain treatment for opioid addiction, both inpatient and outpatient, that helps citizens to navigate the human services system, and that helps citizens understand and exercise their rights under a managed care system.*

3.1.2 Medication-Assisted Treatment (MAT)

Action Step: *GCADA should coordinate with the appropriate State agencies, such as the Division of Consumer Affairs and the Department of Health, along with the State’s medical schools and the professional licensing boards representing substance abuse treatment professionals, to develop training materials and curricula to ensure that all treatment professionals understand the benefits and risks associated with the use of medications such as buprenorphine.*

3.1.3 “Parity” and Other Issues Concerning Health Insurance Coverage

Action Step: *GCADA should work with lawmakers, such as the members of the Senate Oversight Committee, to facilitate meaningful discussions about insurance practices that create barriers to mental health and substance abuse treatment.*

3.1.4 Addressing the “NIMBY” Barrier to Expanding Treatment Capacity

Action Step: *GCADA should coordinate with lawmakers on addressing the practice of using land use statutes and ordinances to impede the construction of new substance abuse treatment facilities that are needed to service the addiction treatment needs of local residents.*

3.1.5 Access to Treatment in County Jails

Action Step: *GCADA should authorize the Task Force to hold a hearing to discuss the effectiveness of, as well as the policy and practical challenges in providing substance abuse and mental health diagnostic and treatment services to county jail inmates, using existing programs as models.*

3.2 Educating the Public

3.2.1 The Need for a Sophisticated Campaign Strategy

Action Step: *GCADA should work with other prevention stakeholders, including the Division of Mental Health and Addiction Services, the United States Drug Enforcement Administration, and the Partnership for a Drug-Free New Jersey, to coordinate the development of a comprehensive multimedia and multicultural public awareness campaign. This public awareness initiative should become a public-private partnership involving the pharmaceutical and health care insurance industries. GCADA should monitor the impact of the comprehensive public awareness campaign, and refine it as needed.*

3.3 Coordinating the Contributions of Schools and Colleges

3.3.1 Updating Alcohol and Drug-Related Curricula

Action Step: *GCADA should authorize the Task Force – in partnership with stakeholders such as the Department of Education, SACs, SROs, DARE officers, Municipal Alliances, and educators – to coordinate and oversee the effort in updating core curricula standards pertaining to substance abuse and in developing and disseminating updated curricula that address the problem of prescription drug abuse.*

3.3.2 Peer-to-Peer Programs

Action Step: *As a component to the effort to update and disseminate school curricula addressing the problem of opiate abuse, GCADA should work with stakeholders, like the Department of Education, to develop and promote peer education and leadership programs – or take advantage of existing programs as appropriate – to design and communicate effective messages to middle school and high school students about the dangers of prescription drug abuse. Similar peer programs should also be developed in colleges and universities across the State.*

3.3.3 Recognition Training and Procedures for School Staff and Administrators

Action Step: *GCADA should explore with the Attorney General and the Commissioner of Education re-convening the Attorney General’s Education and Law Enforcement Working Group, in order to draft appropriate revisions to the Uniform State Memorandum of Agreement between Education and Law Enforcement Officials and address the problem of prescription drug abuse by or affecting schoolchildren. All school staff members should receive training on prescription drug abuse reporting protocols, and on how to recognize the warning signs of such abuse.*

3.3.4 Recovery High Schools

Action Step: *GCADA should convene a meeting of stakeholders to consider the benefits and impediments to establishing a regional recovery school as a pilot demonstration project. The stakeholders should consider statutory and/or regulatory changes that might be needed to remove barriers that effectively prevent those in this state from replicating educational programs proven to be successful in other jurisdictions.*

3.3.5 Recovery Programs and Services in Colleges

Action Step: *GCADA should convene a summit of officials from state and private colleges and universities, to discuss and evaluate their substance abuse programs and to encourage all schools to provide a broad spectrum of recovery support services, including recovery housing. Experts from out-of-state colleges that have developed exemplary programs should also be invited to share their experience and perspective. GCADA should also develop a campaign to convince parents of college students to inquire about the substance abuse prevention, treatment, and recovery support services that are offered by colleges in New Jersey and in other states.*

3.4 Using State-of-the-Art Technology to Detect and Deter Prescription Drug Abuse: Making Full Use of the New Jersey Prescription Monitoring Program (NJPMMP)

3.4.1 Compulsory Registration and Use of NJPMMP

Action Step: *GCADA should promote a legislative initiative to amend the current law establishing the NJPMMP to require prescribers and dispenser to register with and use the NJPMMP before prescribing or dispensing those controlled dangerous substances with a high risk of abuse.*

3.4.2 Wider Access to NJPMMP Data by Licensed Mental Health and Substance Abuse Treatment Professionals

Action Step: *GCADA should promote a legislative initiative to amend the current law establishing the NJPMMP to expand NJPMMP access to mental health professionals involved in the diagnosis and treatment of substance abuse.*

3.4.3 Interstate Sharing of PMP Data

Action Step: *GCADA should coordinate with the Division of Consumer Affairs in its efforts to link the NJPMMP with the NABP InterConnect as soon as possible to better detect prescription drug abuse and diversion across state lines. The Division should also continue entering into PMP information-sharing compacts with those states in the New Jersey region.*

3.4.4 Real-time Reporting of Prescription Data

Action Step: *GCADA should advance a legislative initiative to amend the current law establishing the NJPMMP to require that pharmacies provide real-time prescription information to NJPMMP, as the prescription is filled or at least within twenty-four hours.*

3.4.5 Electronic Prescription Script

Action Step: *GCADA should collaborate with the Division of Consumer Affairs, in partnership with stakeholders from the insurance industry, managed care providers, and licensed professions involved in prescribing and dispensing, to undertake a study to determine the feasibility of moving toward electronic scripts.*

3.5 Prescribing Standards and Best Practices for Prescribers

3.5.1 Setting the Bar High

Action Step: *GCADA should coordinate with the Division of Consumer Affairs in convening a committee to review professional standards and establish best practices for managing pain and preventing diversion and abuse of prescription medications. The committee should be cross-disciplinary, consisting of representatives from the State Board of Medical Examiners and other licensing boards.*

3.5.2 Staying Abreast of Developments in the Field through Continuing Education

Action Step: *GCADA should enlist the proposed committee to review professional standards and establish best practices for managing pain and preventing prescription drug abuse and diversion, to work in partnership with the State's medical schools to establish a continuing education program that ensures prescribers and other addiction treatment professionals possess the most current information on pain management, opiate abuse, suicide prevention, and addiction treatment.*

Appendices

Appendix A TASK FORCE MEMBERS

FRANK GREENAGEL, LCSW, LCADC, ACSW, ICADC, CJC, MPAP Candidate; Task Force Chairman
Recovery Counselor and Adjunct Professor, Rutgers University

Frank Greenagel oversees recovery housing and coordinates student as well as alumni activities at both the Rutgers University New Brunswick and Newark campuses. Rutgers Alcohol and Drug Assistance Program and Recovery Housing won the 2011 NAADAC Organization of the Year Award and has been featured in the New York Times. Greenagel is an adjunct professor at the Rutgers School of Social Work and also at the School of Communication. He was appointed to the Governor's Council on Alcoholism and Drug Abuse in 2011.

Greenagel is a US Army veteran and maintains a private practice in New Brunswick. He spent three years teaching English at Elizabeth High School and six years working as an outpatient counselor at Hunterdon Drug Awareness. He is an Instructor at the Rutgers Center of Alcohol Studies. He is currently pursuing a Masters in Public Affairs and Politics. He conducts trainings and gives keynote speeches around the country.

ERIC ARAUZ Task Force Vice-Chairman
President and Founder, Arauz Inspirational Enterprises

Eric Arauz is a national behavioral healthcare consultant that lectures, trains and provides keynote addresses at conferences throughout the United States for his New Jersey based consulting firm, AIE, www.mylifemylimits.com. He has earned a medical school faculty appointment for his work on the recovery of co-occurring disorders and the traumas associated with diagnosis, treatment and the long-term non-linear recovery trajectory of serious mental illness combined with addiction. Arauz was awarded a 2009 'Voice' award from SAMHSA/US Department of Health and Human Services. He lectures at Yale University and has been a New York Times contributor. Mr. Arauz is currently a faculty member on SAMHSA's Recovery to Practice grant and hosts Grand Rounds at UCLA, Rutgers, RWJ Medical School as well as NYC hospitals on his concepts pertaining to "Duality of Experience of Recovery Involved in Co-Occurring Disorders." Arauz is also a disabled American veteran that served in Operation Desert Storm in the United States Navy. Eric is the author of an internationally acclaimed book "An American's Resurrection".

KAREN BARNETT

Director of the Bridgeton Municipal Alliance – Youth to Youth Program

Karen Barnett is grounded in 30 years of experience working in the field of social services, 20 years of which are specific to prevention. Barnett is a staunch advocate for holistic prevention, early intervention, rehabilitation and recovery zones for individual and communal reintegration – reunification. Individual, familial and community empowerment are the driving force for Barnett’s advocacy. Her civic resume reflects local, state, national and international affiliations and collaborations where she has demonstrated the ability to utilize her relationships with the community of Bridgeton, faith-based and social service agencies and stakeholders for positive changes in the community.

DR. LOUIS BAXTER, M.D.

President and Executive Medical Director, Professional Assistance Program of New Jersey

Dr. Louis Baxter’s expertise is in addiction medicine. He recently ended his term as President of the American Society Medicine during which ASAM was involved in development of public policy related to addiction care afforded by federal health care reform and enactment of federal mental health and addiction parity. Baxter’s Professional Assistance Program provides education, identification, evaluation, treatment planning, and advocacy services for licensed healthcare and other professionals in recovery from impairing medical conditions and illnesses. Baxter also services as Medical Director of the Division of Mental Health and Addiction Services and as an Assistant Clinical Professor Medicine, University Medicine & Dentistry of New Jersey.

SUSAN BUONOMO

CADC, John Brooks Recovery Center

Susan Buonomo currently is employed as a Certified Alcohol and Drug Counselor at the John Brooks Recovery Center in Atlantic City. There, she facilitates the Women’s Day Program, IOP, for Department of Child Protection and Permanency, as well as outpatient groups that have probation, parole, DCPD and IDRC involvement. Susan is one of the founders of the grassroots organization, serving parents and their children struggling with addiction. Parent-to-Parent whose efforts comprised of successfully advocating for a new funding source, SJI Funding, served 18-24 year-olds in accessing detox and treatment which has been utilized throughout the State of NJ. Additionally, after 7 years of advocacy Daytop South was established in Pittsgrove, NJ. The inspiration for her involvement was losing her 22-year-old son to an overdose from heroin and cocaine in 1997. Expanding addiction treatment in NJ, improving access and quality of care, became a focus of her attention. Susan has testified before the NJ Legislature to increase funding for addiction treatment and yet another mission, to have NJ enact Addiction Parity Legislation. Susan has worked at an outpatient facility and inpatient facility as an Intake Coordinator and Life Skills Counselor in Philadelphia. She has also worked for the NJ Department of Children and Family. Susan realized she was on a path where she is supposed to be after viewing a reading in a prayer book: “Grief is a great teacher; it sends you back to serve and bless the living”.

THOMAS R. CALCAGNI, Esq.

First Assistant Attorney General, Office of the Attorney General

Thomas R. Calcagni serves as First Assistant Attorney General where he assists in overseeing all operations at the Department of Law and Public Safety, including all criminal and consumer protection investigations and prosecutions. He previously served as Director of the New Jersey Division of Consumer Affairs where he managed New Jersey's 46 professional boards, oversaw the State's Controlled Dangerous Substances program, and launched the Division's multi-tiered effort to combat prescription drug abuse and diversion- including Project Medicine Drop, the State's 365-day prescription drug take-back initiative, and the New Jersey Prescription Monitoring Program. Calcagni also devised and directed the State's efforts outlawing dangerous designer drugs. Prior to joining the State, Calcagni served for nine years as an Assistant U.S. Attorney in the United States Attorney's Office, District of New Jersey, where he conducted sensitive investigations and prosecutions of public corruption, narcotics trafficking, and other complex crimes.

DOUGLAS SCOTT COLLIER, M.A., DEA Ret.

***Drug Initiative Coordinator & Law Enforcement Liaison
Office of the Attorney General – Division of Consumer Affairs***

Mr. Collier began his law enforcement career as a police officer with the South Greensburg Police Department. In April 1987, he started his federal career with the Central Intelligence Agency (CIA). In November 1990, Mr. Collier accepted an appointment as a Special Agent with the Drug Enforcement Administration in Washington, D.C. His first duty assignment was in the New York Field Division and has subsequently worked in DEA offices in Atlantic City, Paterson and Newark. As a special agent, Mr. Collier has conducted voluminous investigations targeting international heroin and cocaine networks, money launderers, and organizations involved in trafficking steroids and other dangerous drugs. Due to Special Agent Collier's breadth of experience, he was selected in 2000, for a temporary assignment to the DEA Academy in Quantico, VA to assist in the training of newly hired DEA agents.

In 2002, Special Agent Collier was reassigned as the Demand Reduction Coordinator. In this capacity, Special Agent Collier was responsible for DEA's drug prevention and education efforts statewide. He successfully forged relationships with the state's prevention and treatment partners and was instrumental in formulating several innovated anti-drug prevention training programs that have been adopted by numerous substance abuse organizations.

In 2013, Special Agent Collier accepted a position as the Drug Initiative Coordinator with the Office of the Attorney General. As the Drug Initiative Coordinator, Mr. Collier devises new programs and initiatives to combat drug abuse and diversion of prescription and designer drugs. He works alongside investigators to orchestrate and coordinate their enforcement efforts for overall prosecutorial success. Mr. Collier also has a special focus on efforts to enhance the security of controlled dangerous substances within the medical community, including pharmacy security and the security of the New Jersey Prescription blanks. He manages the Project Medicine Drop with law enforcement officers around the state and conducts outreach programs to increase the awareness regarding the New Jersey Prescription Monitoring Program.

Special Agent Collier holds a B.A. Degree from National College and has earned a Master's Degree from Monmouth University. He is also a certified instructor, an adjunct professor, and has testified as an expert witness in regards to international and domestic narcotic investigations.

JAMES P. CURTAIN

Executive Director, Daytop Village of New Jersey

James P. Curtin is the Executive Director at DAYTOP Village of New Jersey, Inc. a comprehensive behavioral health treatment provider dedicated to providing highly effective and accessible behavioral health services, restoring hope and improving the quality of life for each person served, their families and our communities. DAYTOP has expanded its scope of services from adolescents only to include adults in our community based Outpatient Centers. Additionally, Mr. Curtin serves as the President of the Board of Trustees for the DAYTOP Reverend Joseph H. Hennen Preparatory School. DAYTOP serves approximately 500 individuals annually.

Mr. Curtin serves on the Governor's Council on Alcoholism and Drug Abuse Task Force. Additionally, he is a member of the State of New Jersey Department of Mental Health and Addiction Services Professional Advocacy Committee.

Mr. Curtin has been with DAYTOP for the past twenty-seven years and has spent twenty of those years in various management positions. He has been Executive Director since 2009. A graduate of SUNY NY and an MBA with a license to provide substance abuse counseling in the State of New Jersey, Mr. Curtin specializes in adolescent services and has extensive experience working with families of teenagers suffering from drug addiction. He is a trainer of Strategic Family Therapy and is a CARF (Commission on Accreditation of Rehabilitation Facilities) Surveyor.

PHILIP DEGNAN, Esq.

Executive Director, NJ State Commission of Investigation

Philip Degnan is responsible for the day-to-day operation of the SCI and the oversight of the investigations conducted by the SCI in the areas of organized crime, public corruption, public safety, and the administration of justice in the State of New Jersey. In June 2011 the SCI held a public hearing on the changing dynamic of criminal drug-trafficking in New Jersey, with particular focus on prescription pain killer abuse as the leading edge of a new heroin epidemic. Degnan was an Assistant U.S. Attorney for the District of New Jersey prior to joining the SCI and served in Public Protection and the National Security Units where he successfully prosecuted cases involving narcotics trafficking as well as other federal crimes and handled matters involving national security and U.S. foreign policy, including the prosecution of numerous individuals for exporting military technology to other countries. Degnan was also a litigation associate with Gibbons, Del Deo, Dolan, Griffinger & Vecchione, now Gibbons P.C., working in the firm's civil litigation and criminal defense practice groups.

DONALD HALLCOM, Ph.D.

Director, Prevention and Early Intervention, NJ Department of Human Services- Division of Mental Health and Addiction Services

Donald Hallcom is the Director of Prevention and Early Intervention at the New Jersey Department of Human Services, Division of Mental Health and Addiction Services. He is also responsible for studying/analyzing state and Federal legislation - including Federal healthcare reform legislation - as it relates to and impacts the addictions field. Additionally, he acts as liaison between each of New Jersey's 21 county alcohol and drug abuse directors and the Division; and he supervises both the mental health and addictions consumer advocates in DMHAS. He most recently developed and implemented a statewide system of seventeen regional prevention coalitions. Donald has over 24 years' experience in health and human services and has worked in community-based settings, on research projects, and, now, in state government. He particularly enjoyed the years he spent working at Harlem Hospital, where he got his start in health promotion and disease prevention, and in the South Bronx, where he worked with children with serious emotional disturbances and their families. He also spent several years working in the prevention field at a Federally Qualified Health Center in rural Downeast Maine. Donald has a particular interest in policy, planning, and evaluation. In his current position, he oversees Federal Block Grant funding throughout New Jersey. Donald earned a Ph.D. in Social Welfare from Columbia University and an MA in Political Science from Boston College. He is also actively involved in animal welfare and rescue.

WILLIAM KANE, Esq.

Director, New Jersey Lawyers Assistance Program

William Kane leads the NJLAP which provides free and confidential assistance to attorneys, members of the judiciary, law students, and law graduates with alcohol, drug, gambling, emotional, behavioral, and other personal problems that affect well-being and professional performance. He is a member of the American Bar Association and a participant in the Commission on Lawyers Assistance Program (CoLAP) from inception. Since 1981 he has served on adjunct faculty for the Rutgers Center of Alcohol Studies teaching "Alcoholism and the Law" and "Counseling the Professional Client." Kane was among the nation's first Certified Employee Assistance Professionals and is a Certified Social Worker. He serves as federal confidentiality specialist in the public and private sector and as consultant to student assistance programs. Kane also implemented the first employee assistance program for several national corporations and has clinical experience in diverse treatment modalities. He serves as a consultant on clinical and legal issues with a specialty in ethics, confidentiality laws and regulations.

RICHARD LEVESQUE

Vice President of Public Affairs, MWW Group

Rich is Vice President of Public Affairs at MWW Group. MWW Group is the largest privately held public relations firms in the nation. Rich is also the Mercer County Republican Committee Chairman and the former Executive Director of the Burlington County Republican Committee. Rich is a graduate of Manhattan College, Riverdale, NY, with undergraduate degrees in Finance and Economics. He previously worked as a political consultant with Jamestown Associates, where he consulted for over 50 Congressional campaigns throughout the nation, as well as, numerous nonprofit and 527 groups. Rich was Doug Forrester's Political Director during his 2005 campaign for New Jersey Governor. Besides working for state and federal candidates, Rich has managed and consulted on dozens of local and county elections too.

Rich has worked on national campaigns as well. He has an extensive background in grassroots advocacy while working with many national non-profit and 527 groups on issues that range from technology initiatives to immigration reform. While consulting on national political campaigns, Rich worked with national trade associations and numerous political action committees.

He has served on the New Jersey Council on Local Mandates. Rich was elected to the Robbinsville Township Council in November 2008. He was unanimously elected by his fellow Council members to serve as Council President in July 2009. He also serves on the Robbinsville Township Open Space Advisory Committee, the Robbinsville Township Economic Development Advisory Committee and formed the Robbinsville Municipal Alliance on Prevention of Drug and Alcohol Abuse. Rich has been able to secure grant funding from the state and county to fully subsidize the activities of the committees he serves. Rich also currently serves on the Board of Directors of a nationally recognized substance abuse organization and non-profit located in Hamilton New Jersey, Recovery Advocates of New Jersey. He is a founding member and former board member of a recovery resource group called City of Angels, also located in Hamilton New Jersey.

JAMES MCGREEVEY, Esq.

Counselor, Integrity House Program / Hudson County Correctional Center

Former New Jersey Governor Jim McGreevey works with the women of the Integrity House Program at the Hudson County Correctional Center. McGreevey presently guides and directs the Integrity House initiative's spiritual counseling as well as works with the women upon discharge to secure mentoring; a continued commitment to principles of recovery; and, reintegration into the Hudson County community. Having pursued seminary education and training, he served his field education working with formerly incarcerated women and men at Exodus Transitional Ministry in Harlem, New York City.

McGreevey previously served in elected state and local government. He also served as Regional Manager, Merck and Company; as Executive Director, NJ State Parole Board; with the NJ Assembly Majority Office; and as Assistant Prosecutor in Middlesex County. He holds degrees from Columbia University, Georgetown University, Harvard University, and General Theological Seminary.

PAUL RESSLER, CPA
GCADA, Public Member

Paul was born and raised in New Jersey and, except for one year in Vietnam as a medic with the 1st Air Calvary, he has spent his entire life in New Jersey. Born in Jersey City, his formative years were spent in Union City. He completed his high school education in Fairlawn and thereafter entered the military. After completing his military tour of duty his undergraduate education began in Ocean County College. He graduated from Rider University with a BA in Commerce. Paul worked in public accounting and received a CPA license in 1975 after which he started his own accounting practice. He has spent the rest of his years building his own business.

His interest in adolescent drug treatment began in 2004 when his son Corey's life was impacted by the disease of addiction. Paul became dynamic in the world of recovery and interacted with the Hamilton New Jersey Board of Education assisting in the improvement of additional services and the recognition of drug abuse in the Hamilton high schools and middle schools. As a result of his grass roots efforts there are now seven Student Assistant Counselors (SAC) in the township. He recently testified at both the Senate and Assembly Judiciary Committee Hearings as a proponent of the Good Samaritan Bill (911 Law) which after great debate became the Overdose Prevention Act which was signed into law by the Governor of New Jersey on May 2, 2013. He is the current Vice Chairman of the board of trustees of Daytop-New Jersey whose mission is to deliver a comprehensive substance abuse co-occurring treatment and education program to male and female adolescents. An advocate with the National Council on Alcoholism and Drug Dependence – New Jersey (NCADD-NJ), he was a member of the team that organized the Science of Addiction Program that was recently held at Mercer County Community College. Paul currently serves on the Governor's Council on Alcoholism and Drug Abuse (GCADA) and he has been appointed to the Task Force on Heroin and Other Opiate Use by New Jersey's Youth and Young Adults. He also is the Chairperson for GCADA Military and Veterans Committee. Mr. Ressler introduced the Re-Entry Group sessions for adolescents completing the Daytop Program. Paul is a current member of the Division of Mental Health and Addiction Services GCADA Overdose Workgroup. He is a Graduate of the Recovery Coach Academy – 2013.

His mission is simple and comes from an impassioned heart due to the death of his son Corey in July 2010; that mission is to save lives from the disease of addiction.

RON SUSSWEIN, Esq.

Assistant Attorney General, Division of Criminal Justice, Office of the Attorney General

Ron Susswein is an Assistant Attorney General in the Division of Criminal Justice, and currently serves as Counsel to the Division. He has previously served as Assistant Counsel to the Governor, and has also served as Special Assistant to several Attorneys General.

Mr. Susswein graduated with honors from the Georgetown University Law Center. He has served in the Division of Criminal Justice as the Deputy Director for Policy, and later as Deputy Director for Major Crimes, supervising the Division's Organized Crime and Racketeering Bureau, Major Narcotics Bureau, Appellate Bureau, Casino Prosecution Section, Office of Bias Crimes and Community Relations, and Computer Analysis and Technology Unit (cyber crimes).

Mr. Susswein has drafted a number of statutes, including the Comprehensive Drug Reform Act of 1987. Mr. Susswein also drafted statutes for the President's Commission on Model State Drug Laws, including the "Criminal Justice Treatment Act," which called for providing treatment for addicted offenders. Mr. Susswein has played an important role in the development and implementation of New Jersey's Drug Court program, and drafted the statute that authorizes courts to impose treatment in lieu of an otherwise mandatory term of imprisonment.

DEBRA WENTZ, Ph.D.

CEO, NJ Association of Mental Health and Addiction Agencies

As CEO of the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA), Debra L. Wentz, Ph.D. provides bold and innovative leadership and strategic planning, which has enabled her to transform a small, unknown organization into an award-winning trade association and to create a wholly owned private, nonprofit charitable organization, the New Jersey Mental Health Institute (NJMHI).

Dr. Wentz continually participates in initiatives to eliminate stigma and discrimination through both her professional roles, as well as part of her personal commitment. For example, she directed the development of NJMHI's campaigns; and under NJAMHAA, she launched a successful public service announcement (PSA) campaign, Famous Faces: Erasing Stigma and Discrimination, which was recognized with an NJ Astra/ADDY Award, Best of Show – PSA from the New Jersey Communications and Marketing Association and a Telly Award – First Place, Public Service Category, PSA from Cable Television, both in 1998. In addition, Dr. Wentz takes every opportunity to educate and advocate to state and federal government leaders, as well as the general public about the importance of comprehensive parity for mental illnesses and addictions.

Dr. Wentz participated in various events that aim to eliminate stigma and address other behavioral health related issues. For example, she led a collaborative effort with several fellow stakeholder organizations to present Changing Minds: Uniting against Stigma and Discrimination – A Joint New Jersey Effort to Overcome Barriers to Treating and Recovering from Mental Illness in 2001. NJAMHAA and member Daytop Village of New Jersey hosted Silencing the Stigma: Enabling Progress from Recovery from Addictions and Mental Illnesses in 2011.

What matters most to Dr. Wentz is making a difference to improve others' lives, especially vulnerable children and adults. Beginning immediately after the tsunami in Southeast Asia in December 2004, she

developed the Sri Lanka Mental Health Relief Project through NJMHI. Mental health experts volunteered to train individuals in Sri Lanka to identify and treat survivors experiencing mental health problems. To date, this project has positively impacted 200,000 individuals. In 2012, NJMHI developed trilingual, culturally sensitive, informational materials that were well received in Sri Lanka. Now, Dr. Wentz is focused on helping individuals impacted by Superstorm Sandy.

Dr. Wentz earned a doctoral degree from the University of Paris; a second doctoral degree and an MA degree from the University of Connecticut; and an Executive MBA from the Wharton Business School, University of Pennsylvania. She completed undergraduate work at Goucher College, Maryland. She is bilingual in French and English.

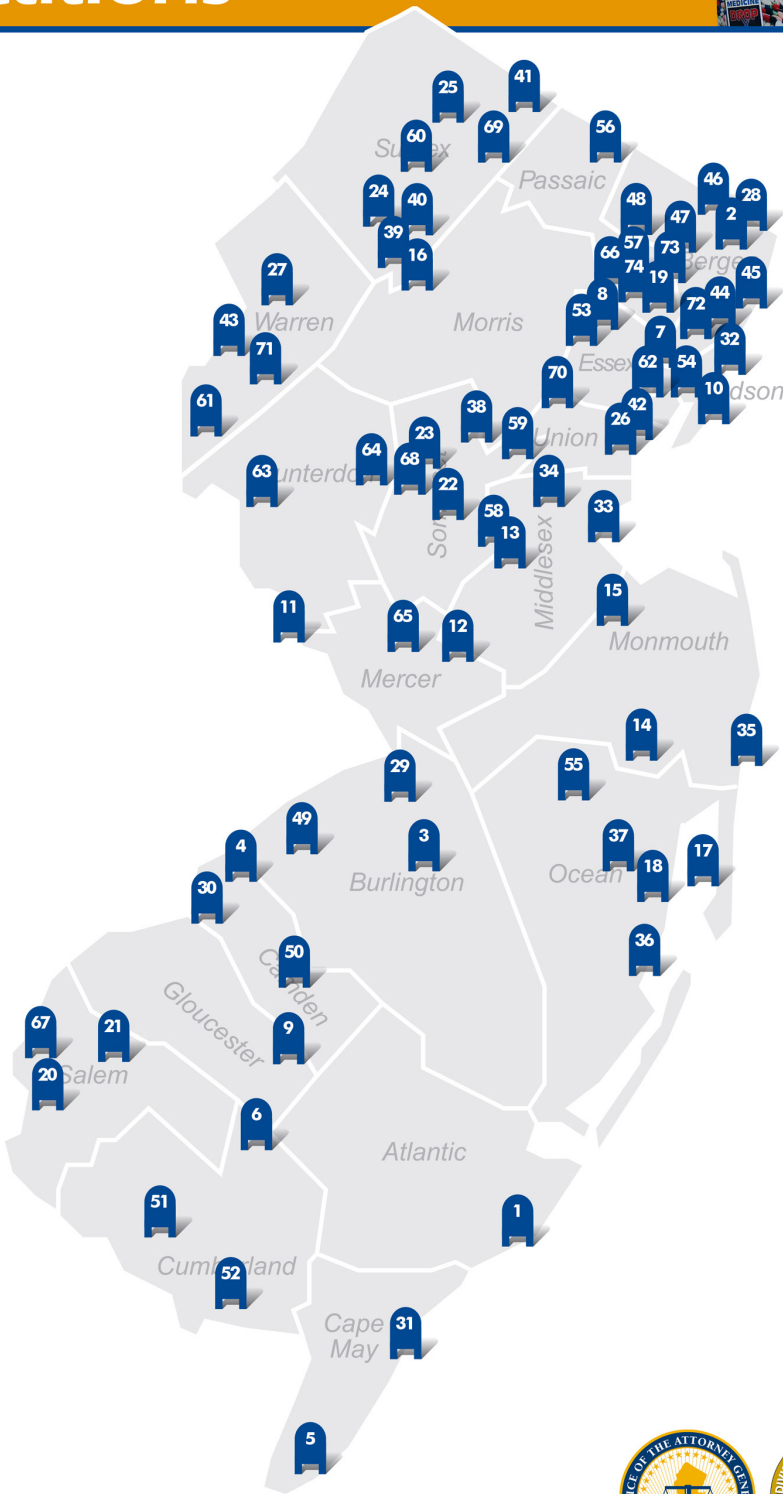
Appendix B HEARING SCHEDULE

Task Force on Heroin and Other Opiate Use by New Jersey's Youth and Young Adults

	Meeting Date	Location	Topic Areas
Public Hearing #1	Tuesday, May 29, 2012	State House Annex, Committee Room 4 125 West State Street Trenton, NJ 08625	Introduction of the heroin and opiate use problem in NJ's youth and young adults
Public Hearing #2	Tuesday, July 10, 2012	Daytop, New Jersey 80 West Main Street Mendham, NJ 07945	Law enforcement perspective; Federal perspective on prescription painkiller epidemic; Prescription Monitoring Program overview
Public Hearing #3	Wednesday, August 29, 2012	Monmouth County Library Headquarters 125 Symmes Road Manalapan, NJ 07726	Medication assisted addiction treatment; Treatment of adolescent and young adult opioid addiction
Public Hearing #4	Tuesday, October 2, 2012	Cooper University Hospital One Cooper Plaza Camden, NJ 08103	Mortality data from the State Medical Examiner's Office; Prevention efforts in NJ

Appendix C
PROJECT MEDICINE DROP

Project Medicine Drop Locations



Project Medicine Drop Locations



1. Atlantic County – Atlantic City P.D.
44. Bergen County – Leonia P.D.
45. Bergen County – Palisades Park P.D.
2. Bergen County – Paramus P.D.
46. Bergen County – Park Ridge P.D.
72. Bergen County – Ridgefield P.D.
28. Bergen County – River Vale P.D.
47. Bergen County – Township of Washington P.D.
48. Bergen County – Waldwick P.D.
29. Burlington County – Burlington Township P.D.
49. Burlington County – Mansfield Township P.D.
3. Burlington County – State Police Barracks – Red Lion
4. Camden County – Cherry Hill P.D.
30. Camden County – Haddon Heights P.D.
50. Camden County – Voorhees P.D.
5. Cape May County – Lower Township P.D.
31. Cape May County – Stone Harbor P.D.
51. Cumberland County Sheriff’s Office – Cumberland
52. Cumberland County – State Police Barracks – Pt. Norris
6. Cumberland County – Vineland P.D.
7. Essex County – Belleville P.D.
53. Essex County – Caldwell P.D.
62. Essex County – Newark P.D.
8. Essex County – North Caldwell P.D.
9. Gloucester County – Mantua P.D.
54. Hudson County – Township of North Bergen P.D.
10. Hudson County Sheriff’s Office – Jersey City
32. Hudson County – West New York P.D.
63. Hunterdon County – Frenchtown P.D.
11. Hunterdon County – Lambertville P.D.
64. Hunterdon County – Readington P.D.
65. Mercer County – Lawrence Township P.D.
12. Mercer County – West Windsor P.D.
13. Middlesex County – East Brunswick P.D.
33. Middlesex County – Perth Amboy P.D.
34. Middlesex County – Sayreville P.D.
14. Monmouth County – Howell P.D.
15. Monmouth County – Marlboro P.D.
35. Monmouth County – Spring Lake Heights P.D.
16. Morris County – State Police Barracks – Netcong
36. Ocean County – Lacey Township P.D.
55. Ocean County – Lakewood P.D.
37. Ocean County – Manchester P.D.
17. Ocean County – Seaside Heights P.D.
18. Ocean County – Toms River P.D.
73. Passaic County – Hawthorne P.D.
19. Passaic County – Little Falls P.D.
56. Passaic County – Ringwood P.D.
57. Passaic County Sheriff’s Office – Paterson
74. Passaic County Sheriff’s Office – Paterson
66. Passaic County Sheriff’s Office – Wayne
67. Salem County – Pennsville P.D.
20. Salem County – Salem City P.D.
21. Salem County – State Police Barracks – Woodstown
38. Somerset County – Bernards Township P.D.
68. Somerset County – Branchburg P.D.
58. Somerset County – Franklin P.D.
22. Somerset County – Hillsborough P.D.
59. Somerset County – North Plainfield P.D.
23. Somerset County Sheriff’s Office – Somerville
60. Sussex County – Andover P.D.
69. Sussex County – Hardyston Township P.D.
39. Sussex County – Hopatcong P.D.
24. Sussex County – Newton P.D.
25. Sussex County – State Police Barracks – Sussex
40. Sussex County – Sparta Township P.D.
41. Sussex County – Vernon Township P.D.
42. Union County – Elizabeth P.D.
70. Union County – Summit P.D.
26. Union County – Union County P.D.
61. Warren County – Phillipsburg P.D.
71. Warren County – Greenwich Township P.D.
27. Warren County – State Police Barracks – Hope
43. Warren County Sheriff’s Office – Belvidere

As of March 11, 2014,
A drop off site has been added in Rahway.



Appendix D

PHARMACY SECURITY BEST PRACTICES



CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
Office of the Director
124 Halsey Street, 7th Floor, Newark NJ



JEFFREY S. CHIESA
Attorney General

ERIC T. KANEFISKY
Acting Director

PHARMACY SECURITY BEST PRACTICES

Published May 1, 2013
New Jersey Division of Consumer Affairs
New Jersey State Board of Pharmacy

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Pharmacy theft and robbery are serious problems fueled by the growing abuse of prescription drugs and their high street value. In discussing pharmacy security with interested parties representing the pharmacy community, the Division of Consumer Affairs has identified certain areas of concern. The intent of this document is to highlight these areas of concern and present potential solutions that pharmacists may consider employing to address those concerns.

The best practices outlined below are recommendations to achieve a safe operating environment for pharmacy employees and customers and lower the potential for adverse events. While implementation of some or all of the recommendations may be impossible for some pharmacies, all pharmacies are encouraged to implement as many of the best practices as they can manage.

Physical Security Controls of Controlled Dangerous Substances

1. Where practical Schedule II (C-II) and Schedule III (C-III) medications in solid dosage form, and other dosage forms (e.g. liquid) as space permits, should be stored in a safe or substantially constructed steel cabinet that is locked at all times (excluding filled CII/C-III prescriptions located in the secured Will-call bins, see paragraph 3 in this section). All C-II and C-III medications that are required to be refrigerated should be kept in a locked refrigerator. Only licensed pharmacists should be permitted access to the safe/steel cabinet and locked refrigerator, and at no time should anyone else access the safe or locked refrigerator. All other CDS may continue to be dispersed throughout the non-controlled inventory.
2. The safe/steel cabinet should comply with the state and federal requirements for storage of small quantities of CDS by non-practitioners found at N.J.A.C. 13:45H-2.2(a)(1) and 21 C.F.R. 1301.72.

3. Will-call bins for C-II and C-III medications should be located in the secured prescription filling area of the pharmacy department (not on shelves by the cashier) and within unobstructed view of the pharmacist during the hours the pharmacy is open. Where practical, the bin should be constructed so that it can be securely locked at night and at all times when the pharmacy is closed.

4. N.J.A.C. 13:39-4.15(b)(3) requires that there be a secure area for receiving packages known to contain CDS, PLD and devices. No deliveries for prescription drugs shall be accepted during the hours the pharmacy or pharmacy department is closed unless adequate security for the storage of such shipments has been provided.

It is recommended that pharmacies receive deliveries of CDS/PLD only during posted store hours, and only when a pharmacist is present to accept and sign for the delivery. It is recommended that upon receipt of CDS/PLD the pharmacist, or, if delegated by the pharmacist, a registered pharmacy technician, open and inspect the contents of the containers to ensure that the totes contain the correct CDS in the correct amounts as soon as practical after receiving delivery. Any discrepancy between the receipt/invoice and actual contents must be immediately reported per regulation. N.J.A.C. 13:39-4.15.

General Security for Pharmacy

1. Pharmacies must comply with regulatory requirements for a monitored security system which transmits an audible, visual or electronic signal warning of intrusion. The security system is required to be equipped with a back-up mechanism to ensure notification or continued operation if the security system is tampered with or disabled. The central station monitoring agreement should be paid for and current. N.J.A.C. 13:39-4.15(b)1

Pharmacies should consider a security system with a cellular backup mechanism to ensure notification or continued operation of the system in the event of power failure or the system is disabled.

2. Consider installing a silent panic alarm.

3. Do not allow unescorted, non-essential personnel in the prescription filling area or pharmacy department (plumbers, building inspectors, accountants, etc.). The RPIC should use due diligence in ensuring the security of the pharmacy as per N.J.A.C. 13:39-4.15

4. Pharmacies should consider utilizing video surveillance technology including quality security cameras placed to capture activity anywhere CDS is stored, counted, held, dispensed or returned to stock, and exits from the pharmacy or the “front end” of a retail store. At minimum, the tapes should be retained three months to help ID potential theft identified during random CDS manual counts. Pharmacies should consider updating to digital recording systems to enhance pharmacy security and reduce storage concerns.

5. Routine pharmacy security features include: alarmed doors/windows with central station monitoring, physical barriers (steel window/door curtains), sensors, sufficient lighting

levels inside and outside the pharmacy, installation of height markers at exit doors.

6. Train staff for prevention and response to robbery.

7. Advertise security to the public and employees.

8. Unwanted or outdated CDS should be properly disposed of or returned per Federal and State regulations.

Frequency of CDS inventory and manual count of pills

1. A Pharmacist should consider maintaining a perpetual inventory for C-II and C-III medications and other items identified to have high street value, e.g. Alprazolam, diazepam, and possibly erectile dysfunction drugs, tramadol etc. The inventory should include:

- Date, drug name, quantity received and invoice number or DEA Form 222 (or Electronic 222) for all medications received.
- Date, drug name, quantity and prescription number for each prescription filled and dispensed.
- Date, drug name, quantity and prescription number for all medication that is filled but not dispensed and is returned to stock
- Date, drug name, and quantity for all medication sent to a reverse distributor or destroyed as waste.

2. A pharmacist should conduct a random manual reconciliation once each month to include at least 5 drugs that are top 10% risk for diversion and 3 that are lower risk for diversion. The Pharmacist should manually sign and date the inventory and reconciliation paperwork each time he/she conducts a manual reconciliation. If the inventory and/or manual reconciliation paperwork is kept electronically, the pharmacist should print it out and manually sign it.

When a pharmacy employs more than one pharmacist, the same pharmacist should not conduct the monthly reconciliation count any two consecutive months.

3. Inventory and manual reconciliation results should be maintained for two years.

4. Each supplier's invoice for Schedule II CDS medications should be stapled to the corresponding DEA -222 Form (or CSOS print-out), on which the pharmacist has recorded the required information for each item received, and should be maintained in a separate file.

5. Inventory for all CDS (Schedule C-II through C-V) should be done once a year on the same day and month that your biennial inventory would usually be completed.

Ordering CDS and verification of shipment upon delivery

1. Only the pharmacist should have the authority to order C-II and C-III CDS.
2. As soon as possible after delivery of the CDS, a pharmacist or pharmacy technician may check-in the order. A pharmacist, other than the individual who did the initial check-in should verify the completeness and accuracy of each order and sign off on each receipt/invoice before placing the CDS into inventory, as described above. Only the pharmacist may physically place the C-II's and C-III's into the safe/steel cabinet.
3. The same person should not have responsibility for ordering and receiving CDS.

Interface with Prescribers

1. A pharmacist who suspects that a practitioner may be indiscriminately prescribing CDS should contact the practitioner to attempt to ascertain whether the prescription is being issued for a legitimate medical purpose. A pharmacist should report practitioners about whom they have substantiated concern to the appropriate professional licensing Board and the Prescription Drug Monitoring Program. N.J.S.A. 45:1-37.
2. A pharmacist who suspects a prescription may be forged or altered¹ should verify the prescriber's phone number to ensure that the number printed on the prescription blank is correct and call to confirm the prescription, verify suspicious oral prescriptions, ask for appropriate practitioner information such as DEA #, utilize caller ID to note telephone number of incoming call, verify ID of person picking up the prescription. A pharmacist could also request a faxed confirmation from the practitioner's office, to confirm a telephone prescription.
3. Exercise caution with internet related transactions, especially fee for filling opportunities and deals that seem too good to be true.

Interface with Customers

1. Require individuals picking up CDS prescriptions to show photo identification at time of purchase if the pharmacist is not familiar with the patient. Photocopies of the identification should be stapled to the original prescription or scanned to the computer profile.
2. Written prescription blanks should not be stored in a way that would allow customer access. That is, kept where customers can reach them or see confidential patient information (to steal, wash, alter, etc.)
3. All pharmacists should register with Division's Prescription Monitoring Program, and should regularly access the PMP when filling prescriptions to monitor for instances of doctor-shopping or abuse. Pharmacies may also consider including drug abuse and treatment information on the drug monograph that is provided to each patient.

4. The pharmacist has the right to refuse to fill a prescription if, in his or her professional judgment, the prescription is outside the scope of the practice of the practitioner; or if the pharmacist has sufficient reason to question the validity of the prescription; or to protect the health and welfare of the patient. N.J.A.C. 13:39-7.12

Self Assessment

Registered Pharmacists in Charge should conduct self-assessments annually and whenever there is a change in RPIC, to ensure that federal and state requirements governing the practice of pharmacy are met. The self-assessment procedure evaluates a variety of concerns to include: pharmacy security measures in place, medication inventory review (expired, overfilled, misbranded, substituted, pilfered), prescription dispensing analysis, required equipment and documentation. The Board of Pharmacy is in the process of creating a self-assessment tool that would be New Jersey specific and available in the future.

¹Some Characteristics of Forged Prescriptions: Prescriber is not from your local area • Patient is unfamiliar to you or is from out of town • Patient exhibits suspicious behavior • Patient is picking up prescription for someone else • Prescription is presented or phoned in near closing time • Prescription is phoned in by practitioner covering after hours or on the weekend • Prescription appears too perfect, or in the alternative, contains errors in spelling or prescribing symbols • Prescription appears to be copied or scanned, is not of proper size or does not appear to have been torn from an official prescription pad.

REPORTING CDS RELATED THEFT/LOSS

Any theft/loss of CDS and PLD must be reported:

1. Contact local police department and report the theft/loss.
2. Submit a Report of Theft or Loss of Controlled Substances form (DDC-52) to the NJ Department of Law and Public Safety, Drug Control Unit.
3. Electronically submit a Report of Theft or Loss of Controlled Substances form (DEA Form 106) to the Drug Enforcement Administration, Office of Diversion Control. The website is www.deadiversion.usdoj.gov. A paper version of DEA Form 106 can be obtained by writing DEA Headquarters, Attn: Regulatory Section/ODG, 8701 Morrisette Drive, Springfield, VA 22152.
4. Report the theft/loss to Anthony Rubinaccio, Executive Director, New Jersey Board of Pharmacy by submitting a copy of the DEA-Form 106.

Upon receiving notification that specific NJPB's have been reported lost or stolen by a practitioner and if presented, prior to dispensing:

1. Verify the prescription's authenticity with the prescriber.
2. Contact your local police department.
3. Submit a NJPB Incident Report to the NJPB Unit of the Division of Consumer Affairs.

To report a suspected indiscriminate/overprescribing practitioner, or an impaired practitioner, contact the practitioner's respective licensing Board by telephone. An online complaint form can also be filed (see the New Jersey Division of Consumer Affairs website at: <http://www.nj.gov/oag/ca/boards.htm>)

Disposal of unwanted or outdated CDS is accomplished by first completing a DEA Form 41 and submitting same to the Drug Enforcement Administration (DEA)(1-888-346-1071). The pharmacy would next contact the NJ Drug Control Unit, complete a DDC Form 51, submit same and await further instructions.

STATE OF NEW JERSEY CONTROLLED SUBSTANCE RELATED DIRECTORY

NJPB Unit

Division of Consumer Affairs
P.O. Box 45045
124 Halsey Street
Newark, NJ 07101.
(973) 504-6558
www.NJConsumerAffairs.gov/drug/

Drug Control Unit

Division of Consumer Affairs
P.O. Box 45045
Newark NJ 07101.
(973) 796-4220 and (973) 504-6411
www.NJConsumerAffairs.gov/drug/

New Jersey Prescription Monitoring Program

P.O. Box 45027
124 Halsey Street, 6th Floor
Newark, NJ
(800)242-5846
www.NJConsumerAffairs.gov/pmp/

Enforcement Bureau

New Jersey Division of Consumer Affairs
124 Halsey Street, 3rd Floor
Newark, NJ 07101
(973) 504-6300

New Jersey Board of Pharmacy

ATTN: Anthony Rubinaccio, Executive Director
P.O. Box 45013
Newark, NJ 07101
(973)504-6450
www.NJConsumerAffairs.gov/pharm/

New Jersey State Board of Dentistry

ATTN: Jonathan Eisenmenger, Executive Director
PO Box 45005
Newark, NJ 07101
(973) 504-6405
www.NJConsumerAffairs.gov/dentistry/

New Jersey Board of Nursing

ATTN: George Hebert, Executive Director
PO Box 45010
Newark, NJ 07101
(973) 504-6430
www.NJConsumerAffairs.gov/nursing/

New Jersey State Board of Medical Examiners

ATTN: William Roeder, Executive Director
P.O. Box 183
Trenton, NJ 08625
(609) 826-7100
www.NJConsumerAffairs.gov/bme/

Board of Veterinary Medical Examiners

ATTN: Jonathan Eisenmenger, Executive Director
PO Box 45020
Newark, NJ 07101
(973) 504-6500
www.NJConsumerAffairs.gov/vetmed/

Appendix E

OVERDOSE PREVENTION ACT

CHAPTER 46

AN ACT concerning opioid antidotes and overdose prevention, and supplementing Title 24 of the Revised Statutes and Title 2C of the New Jersey Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.24:6J-1 Short title.

1. This act shall be known and may be cited as the “Overdose Prevention Act.”

C.24:6J-2 Findings, declarations relative to overdose prevention.

2. The Legislature finds and declares that encouraging witnesses and victims of drug overdoses to seek medical assistance saves lives and is in the best interests of the citizens of this State and, in instances where evidence was obtained as a result of seeking of medical assistance, these witnesses and victims should be protected from arrest, charge, prosecution, conviction, and revocation of parole or probation for possession or use of illegal drugs. Additionally, naloxone is an inexpensive and easily administered antidote to an opioid overdose. Encouraging the wider prescription and distribution of naloxone or similarly acting drugs to those at risk for an opioid overdose, or to members of their families or peers, would reduce the number of opioid overdose deaths and be in the best interests of the citizens of this State. It is not the intent of the Legislature to protect individuals from arrest, prosecution or conviction for other criminal offenses, including engaging in drug trafficking, nor is it the intent of the Legislature to in any way modify or restrict the current duty and authority of law enforcement and emergency responders at the scene of a medical emergency or a crime scene, including the authority to investigate and secure the scene.

C.24:6J-3 Definitions relative to overdose prevention.

3. As used in this act:

“Commissioner” means the Commissioner of Human Services.

“Drug overdose” means an acute condition including, but not limited to, physical illness, coma, mania, hysteria, or death resulting from the consumption or use of a controlled dangerous substance or another substance with which a controlled dangerous substance was combined and that a layperson would reasonably believe to require medical assistance.

“Medical assistance” means professional medical services that are provided to a person experiencing a drug overdose by a health care professional, acting within the scope of his or her lawful practice, including professional medical services that are mobilized through telephone contact with the 911 telephone emergency service.

“Opioid antidote” means naloxone hydrochloride or any other similarly acting drug approved by the United States Food and Drug Administration for the treatment of an opioid overdose.

“Health care professional” means a physician, physician assistant, advanced practice nurse, or other individual who is licensed or whose professional practice is otherwise regulated pursuant to Title 45 of the Revised Statutes, other than a pharmacist, and who, based upon the accepted scope of professional authority, prescribes or dispenses an opioid antidote.

“Patient” includes a person who is not at risk of an opioid overdose but who, in the judgment of a physician, may be in a position to assist another individual during an overdose and who has received patient overdose information as required by section 5 of this act on the indications for and administration of an opioid antidote.

C.24:6J-4 Immunity from liability for certain prescribers, dispensers.

4. a. A health care professional or pharmacist who, acting in good faith, directly or through a standing order, prescribes or dispenses an opioid antidote to a patient capable, in the judgment of the health care professional, of administering the opioid antidote in an emergency, shall not, as a result of the professional’s acts or omissions, be subject to any criminal or civil liability, or any professional disciplinary action under Title 45 of the Revised Statutes for prescribing or dispensing an opioid antidote in accordance with this act.

b. A person, other than a health care professional, may in an emergency administer, without fee, an opioid antidote, if the person has received patient overdose information pursuant to section 5 of this act and believes in good faith that another person is experiencing an opioid overdose. The person shall not, as a result of the person’s acts or omissions, be subject to any criminal or civil liability for administering an opioid antidote in accordance with this act. In addition, the immunity provided for in section 7 or section 8 of P.L.2013, c.46 (C.2C:35-30 or C.2C:35-31) also shall apply to a person acting pursuant to this section, provided that the requirements of section 7 or section 8 also have been met.

C.24:6J-5 Patient overdose information.

5. a. A health care professional prescribing or dispensing an opioid antidote to a patient shall ensure that the patient receives patient overdose information. This information shall include, but is not limited to: opioid overdose prevention and recognition; how to perform rescue breathing and resuscitation; opioid antidote dosage and administration; the importance of calling 911 emergency telephone service for assistance with an opioid overdose; and care for an overdose victim after administration of the opioid antidote.

b. In order to fulfill the distribution of patient overdose information required by subsection a. of this section, the information may be provided by the health care professional, or a community-based organization, substance abuse organization, or other organization which addresses medical or social issues related to drug addiction that the health care professional maintains a written agreement with, and that includes: procedures for providing patient overdose information; information as to how employees or volunteers providing the information will be trained; and standards for documenting the provision of patient overdose information to patients.

c. The provision of patient overdose information shall be documented in the patient’s medical record by a health care professional, or through similar means as determined by any written agreement between a health care professional and an organization as set forth in subsection b. of this section.

d. The Commissioner of Human Services, in consultation with Statewide organizations representing physicians, advanced practice nurses, or physician assistants, or communitybased programs, substance abuse programs, syringe access programs, or other programs which address medical or social issues related to drug addiction, may develop and disseminate training materials in video, electronic, or other formats to health care professionals or organizations operating community-based programs, substance abuse programs, syringe access programs, or other programs which address medical or social issues

related to drug addiction, to facilitate the provision of patient overdose information.

C.24:6J-6 Awarding of grants.

6. a. The Commissioner of Human Services may award grants, based upon any monies appropriated by the Legislature, to create or support local opioid overdose prevention, recognition, and response projects. County and municipal health departments, correctional institutions, hospitals, and universities, as well as organizations operating community-based programs, substance abuse programs, syringe access programs, or other programs which address medical or social issues related to drug addiction may apply to the Department of Human Services for a grant under this section, on forms and in the manner prescribed by the commissioner.

b. In awarding any grant, the commissioner shall consider the necessity for overdose prevention projects in various health care facility and non-health care facility settings, and the applicant's ability to develop interventions that will be effective and viable in the local area to be served by the grant.

c. In awarding any grant, the commissioner shall give preference to applications that include one or more of the following elements:

(1) prescription and distribution of naloxone hydrochloride or any other similarly acting drug approved by the United States Food and Drug Administration for the treatment of an opioid overdose;

(2) policies and projects to encourage persons, including drug users, to call 911 for emergency assistance when they witness a potentially fatal opioid overdose;

(3) opioid overdose prevention, recognition, and response education projects in syringe access programs, drug treatment centers, outreach programs, and other programs operated by organizations that work with, or have access to, opioid users and their families and communities;

(4) opioid overdose recognition and response training, including rescue breathing, in drug treatment centers and for other organizations that work with, or have access to, opioid users and their families and communities;

(5) the production and distribution of targeted or mass media materials on opioid overdose prevention and response;

(6) the institution of education and training projects on opioid overdose response and treatment for emergency services and law enforcement personnel; and

(7) a system of parent, family, and survivor education and mutual support groups.

d. In addition to any moneys appropriated by the Legislature, the commissioner may seek money from the federal government, private foundations, and any other source to fund the grants established pursuant to this section, as well as to fund on-going monitoring and evaluation of the programs supported by the grants.

C.2C:35-30 Immunity from liability, certain circumstances, for persons seeking medical assistance for someone experiencing a drug overdose.

7. a. A person who, in good faith, seeks medical assistance for someone experiencing a drug overdose shall not be:

(1) arrested, charged, prosecuted, or convicted for obtaining, possessing, using, being under the influence of, or failing to make lawful disposition of, a controlled dangerous substance or controlled substance analog pursuant to subsection a., b., or c. of N.J.S.2C:35-10;

(2) arrested, charged, prosecuted, or convicted for inhaling the fumes of or possessing any toxic chemical pursuant to subsection b. of section 7 of P.L.1999, c.90 (C.2C:35-10.4);

(3) arrested, charged, prosecuted, or convicted for using, obtaining, attempting to obtain, or possessing any prescription legend drug or stramonium preparation pursuant to subsection b., d., or e. of section 8 of P.L.1999, c.90 (C.2C:35-10.5);

(4) arrested, charged, prosecuted, or convicted for acquiring or obtaining possession of a controlled dangerous substance or controlled substance analog by fraud pursuant to N.J.S.2C:35-13;

(5) arrested, charged, prosecuted, or convicted for unlawfully possessing a controlled dangerous substance that was lawfully prescribed or dispensed pursuant to P.L.1998, c.90 (C.2C:35-24);

(6) arrested, charged, prosecuted, or convicted for using or possessing with intent to use drug paraphernalia pursuant to N.J.S.2C:36-2 or for having under his control or possessing a hypodermic syringe, hypodermic needle, or any other instrument adapted for the use of a controlled dangerous substance or a controlled substance analog pursuant to subsection a. of N.J.S.2C:36-6;

(7) subject to revocation of parole or probation based only upon a violation of offenses described in subsection a. (1) through (6) of this section, provided, however, this circumstance may be considered in establishing or modifying the conditions of parole or probation supervision.

b. The provisions of subsection a. of this section shall only apply if:

(1) the person seeks medical assistance for another person who is experiencing a drug overdose and is in need of medical assistance; and

(2) the evidence for an arrest, charge, prosecution, conviction, or revocation was obtained as a result of the seeking of medical assistance.

c. Nothing in this section shall be construed to limit the admissibility of any evidence in connection with the investigation or prosecution of a crime with regard to a defendant who does not qualify for the protections of this act or with regard to other crimes committed by a person who otherwise qualifies for protection pursuant to this act. Nothing in this section shall be construed to limit any seizure of evidence or contraband otherwise permitted by law. Nothing herein shall be construed to limit or abridge the authority of a law enforcement officer to detain or take into custody a person in the course of an investigation or to effectuate an arrest for any offense except as provided in subsection a. of this section. Nothing in this section shall be construed to limit, modify or remove any immunity from liability currently available to public entities or public employees by law.

C.2C:35-31 Protections for certain persons experiencing a drug overdose.

8. a. A person who experiences a drug overdose and who seeks medical assistance or is the subject of a good faith request for medical assistance pursuant to section 4 of this act shall not be:

(1) arrested, charged, prosecuted, or convicted for obtaining, possessing, using, being under the influence of, or failing to make lawful disposition of, a controlled dangerous substance or controlled substance analog pursuant to subsection a., b., or c. of N.J.S.2C:35-10;

(2) arrested, charged, prosecuted, or convicted for inhaling the fumes of or possessing any toxic chemical pursuant to subsection b. of section 7 of P.L.1999, c.90 (C.2C:35-10.4);

(3) arrested, charged, prosecuted, or convicted for using, obtaining, attempting to obtain,

or possessing any prescription legend drug or stramonium preparation pursuant to subsection b., d., or e. of section 8 of P.L.1999, c.90 (C.2C:35-10.5);

(4) arrested, charged, prosecuted, or convicted for acquiring or obtaining possession of a controlled dangerous substance or controlled substance analog by fraud pursuant to N.J.S.2C:35-13;

(5) arrested, charged, prosecuted, or convicted for unlawfully possessing a controlled dangerous substance that was lawfully prescribed or dispensed pursuant to P.L.1998, c.90 (C.2C:35-24);

(6) arrested, charged, prosecuted, or convicted for using or possessing with intent to use drug paraphernalia pursuant to N.J.S.2C:36-2 or for having under his control or possessing a hypodermic syringe, hypodermic needle, or any other instrument adapted for the use of a controlled dangerous substance or a controlled substance analog pursuant to subsection a. of N.J.S.2C:36-6;

(7) subject to revocation of parole or probation based only upon a violation of offenses described in subsection a. (1) through (6) of this section, provided, however, that this circumstance may be considered in establishing or modifying the conditions of parole or probation supervision.

b. The provisions of subsection a. of this section shall only apply if the evidence for an arrest, charge, prosecution, conviction or revocation was obtained as a result of the seeking of medical assistance.

c. Nothing in this section shall be construed to limit the admissibility of any evidence in connection with the investigation or prosecution of a crime with regard to a defendant who does not qualify for the protections of this act or with regard to other crimes committed by a person who otherwise qualifies for protection pursuant to this act. Nothing in this section shall be construed to limit any seizure of evidence or contraband otherwise permitted by law. Nothing herein shall be construed to limit or abridge the authority of a law enforcement officer to detain or take into custody a person in the course of an investigation or to effectuate an arrest for any offense except as provided in subsection a. of this section. Nothing in this section shall be construed to limit, modify or remove any immunity from liability currently available to public entities or public employees by law.

9. Sections 1 through 6 of this act shall take effect on the first day of the second month next following enactment, except that the Commissioner of Human Services shall take any anticipatory action in advance thereof as shall be necessary for the implementation of this act and sections 7 and 8 shall take effect immediately.

Approved May 2, 2013.

Appendix F

OVERDOSE PREVENTION ACT DIRECTIVE



CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lieutenant Governor

State of New Jersey
OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
PO BOX 080
TRENTON, NJ 08625-0080

JOHN J. HOFFMAN
Acting Attorney General

TO: All County Prosecutors
All Municipal Prosecutors
All County Sheriffs
All Police Chief Executives
Joseph R. Fuentes, Superintendent
New Jersey State Police
Elie Honig, Director
New Jersey Division of Criminal Justice

FROM: John J. Hoffman, Acting Attorney General

SUBJECT: Directive to Ensure Uniform Statewide Enforcement of the "Overdose Prevention Act"

DATE: June 25, 2013

1. Introduction and Overview

On May 2, 2013, Governor Christie signed into law the "Overdose Prevention Act" as P.L. 2013, c. 46. A copy of the new law is attached. Pursuant to my authority and responsibility under the Criminal Justice Act of 1970, N.J.S.A. 52:17B-97 et seq., to ensure the uniform and efficient enforcement of the criminal laws, I hereby issue this Directive to ensure that all police and prosecuting agencies comply with the requirements of the new law.

The provisions of the Overdose Prevention Act that are most relevant to law enforcement officers and agencies are codified at N.J.S.A. 2C: 35-30 and 2C:35-31. The overarching purpose of the statute is to encourage persons to seek immediate medical assistance whenever a drug overdose occurs. In the past, there have been instances where persons were reluctant or unwilling to call authorities for help for fear that this might lead to an arrest or prosecution for illegal drug use or possession. It is vitally important that medical assistance be rendered as quickly as possible to



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persons who are experiencing a drug overdose. The Governor and Legislature have thus determined that lives can be saved by alleviating the fear of arrest and prosecution that might discourage or delay a call for help. To accomplish this vital goal, the new law provides legal protection in the form of immunity from arrest, prosecution, or conviction for a use or simple possession drug charge when a person, in good faith, seeks medical assistance for him/herself or for another. The request for medical assistance that triggers the law's immunity feature may be made by means of the 9-1-1 telephone emergency system or by any other means.

In order to achieve the salutary goal of the Drug Overdose Prevention Act, all law enforcement officers and prosecutors must be familiar with the new law and take steps to ensure that the legal protections afforded under the statute are respected and uniformly enforced throughout the State.

2. Specific Crimes and Offenses That Are Subject to Immunity From Arrest and Prosecution

The Overdose Prevention Act specifically provides that when a person, in good faith, seeks medical assistance for a person believed to be experiencing a drug overdose, whether the person is seeking assistance for him/herself or for another, the person calling for help and the person experiencing the overdose shall not be arrested, charged, prosecuted, or convicted for certain specified criminal offenses. The specified crimes and offenses are as follows:

- 1) obtaining, possessing, using, being under the influence, or failing to make lawful disposition of any controlled dangerous substance or analog in violation of subsection a., b., or c. of N.J.S.A. 2C:35-10;
- 2) inhaling the fumes or possessing a toxic chemical in violation of subsection b. of N.J.S.A. 2C:35-10.4;
- 3) using, obtaining, attempting to obtain, or possessing any prescription legend drug or stramonium preparation in violation of subsection b., d., or e. of N.J.S.A. 2C:35-10.5;
- 4) acquiring or obtaining a controlled dangerous substance or analog by fraud in violation of N.J.S.A. 2C:35-13;
- 5) unlawfully possessing a controlled dangerous substance that was lawfully prescribed or dispensed in violation of N.J.S.A. 2C:35-24; and
- 6) using or possessing with intent to use drug paraphernalia in violation of N.J.S.A. 2C:36-2, or having under control or possessing a hypodermic syringe or other instrument for using a controlled dangerous substance or analog in violation of subsection a. of N.J.S.A. 2C:36-6.

3. Crimes That Are Not Subject to the Statutory Immunity Feature

It is important to note that the immunity from arrest, prosecution, and conviction afforded under the statute applies only to those crimes and offenses that specifically are enumerated in N.J.S.A. 2C:35-30(a)(1-6) and 2C:35-31(a) (1-6), and that are comprehensively set forth in Section 2 of this Directive. These specified drug-related offenses commonly are referred to as “simple possession” offenses. It is critical to note that the statute does not apply to or in any way limit the authority or discretion of law enforcement officers or prosecutors to investigate, arrest or prosecute an offense involving the manufacture, distribution, or possession with intent to distribute an illicit substance or paraphernalia. The legislative findings set forth in the statute make clear in this regard that, “[i]t is not the intent of the Legislature to protect individuals from arrest, prosecution or conviction for other criminal offenses, including engaging in drug trafficking....” N.J.S.A. 24:6J-2.

Nor does the statute preclude an arrest, prosecution or conviction for the crime of strict liability for drug-induced death in violation of N.J.S.A. 2C:35-9, or the offense of driving while under the influence of an intoxicating substance in violation of N.J.S.A. 39:4-50 or any related drunk/drugged driving offense or indictable crime.

4. Uniform Statewide Enforcement Policy Where Multiple Persons Collaborate in a Request for Medical Assistance

The literal text of the statute affords immunity only to the specific individual who actually sought medical assistance (*e.g.*, the person who placed a 9-1-1 telephone call) and to the person who experienced a drug overdose and was the subject of a good faith request for medical assistance made by another. There may be situations, however, where two or more persons are present when the request for medical assistance is made. Consistent with the spirit of the law and its overriding purpose to reduce disincentives to seeking prompt medical help, where it can reliably be determined that two or more persons were present at the time that the request for medical assistance was made and were aware of and participating in that request, police and prosecutors should proceed as if those persons had collaborated in making the request for medical assistance, even though only one of them actually placed the call to the 9-1-1 emergency system or otherwise made the request for medical assistance. Persons who in this manner collaborated in making the request for medical assistance should not be arrested or prosecuted for an offense enumerated in Section 2 of this Directive.

This enforcement policy, while arguably not required by the literal terms of the statute, is hereby adopted for sound policy reasons. Persons present at the scene of a drug overdose might be chilled from making a request for medical assistance for fear that such a call to authorities might subject friends, family, or colleagues to arrest or prosecution for drug use or possession. It therefore makes sense to refrain from arresting and/or prosecuting persons who reasonably appear to be associated and collaborating with the person who actually places the call for medical help. This policy is not intended, however, to insulate from arrest and prosecution all persons who happen, for

example, to be in a “crack house” or at a party at which a person experiences an overdose. Rather, it is intended to apply only to those individuals who were aware of and collaborated in the request for medical assistance. For example, police should refrain from arresting a person who was aware that someone else had placed a 9-1-1 call for medical assistance and stayed with the person who was experiencing an overdose until help arrived. This enforcement policy would also apply where a person can demonstrate that he or she left the presence of the overdose victim for the purpose of seeking medical assistance, such as by going to a neighbor’s house to make a 9-1-1 call. It would not apply, however, to those who flee the scene to avoid apprehension without collaborating in a good-faith effort to seek medical assistance, or to any person who had in any way or by any means *discouraged* others from making a call for assistance.

This enforcement policy is intended to effectuate the goal of encouraging persons to initiate timely requests for medical assistance to the greatest extent feasible. It must be recognized that as a practical matter, police investigating an incident may not be able to establish who is entitled to immunity from arrest and prosecution under the statute (*e.g.*, who placed a 9-1-1 call), much less to establish who may have collaborated in the request for medical assistance for purposes of applying the foregoing enforcement policy. Law enforcement officers and prosecutors are expected to apply the law and this enforcement policy in good faith, recognizing that for practical reasons, persons who seek the benefit of the law’s immunity feature must bear responsibility for establishing the factual basis for immunity from arrest or prosecution.

Nothing herein shall be construed to create any rights, privileges, or immunities beyond those expressly established in the Overdose Prevention Act. Nor does the enforcement policy established in this section in any way limit the authority of prosecutors to argue in litigation that the statutory immunity feature does not apply to any individual.

5. Inapplicability of Statutory Immunity When Offense is Discovered Independent of a Request for Medical Assistance

The immunity provisions of the statute apply only when the evidence for an arrest, charge, prosecution or conviction had been obtained as a result of the seeking of medical assistance. N.J.S.A. 2C:35-30(b)(2) and 2C:35-31(b). The immunity feature thus does not extend to simple possession drug offenses that come to the attention of law enforcement by any independent means. Thus, for example, a prosecution for a simple possession drug offense may proceed if the evidence of that offense had been discovered and seized prior to the call for medical assistance (*e.g.*, where police during an encounter see a controlled dangerous substance in plain view and a person on the scene thereafter tells police that he/she or another person is experiencing an overdose and needs medical assistance).

6. Authority to Seize Contraband Even When Immunity Feature Applies

The statute makes clear that it in no way limits the authority of law enforcement officers to seize evidence or contraband, even if the person from whom the evidence was seized is immune from arrest or prosecution for possession of that evidence or contraband. See N.J.S.A. 2C:35-30(c) and 2C:35-31(c).

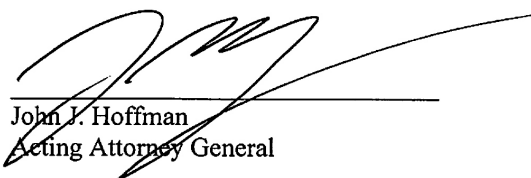
7. Effective Date and Application to Pending Cases

The new law took effect immediately upon its enactment on May 2, 2013. Any pending prosecution for a covered offense should be dismissed on motion of the prosecutor in any case where the evidence necessary to prove the offense had been discovered or learned about as a result of a good faith call for medical assistance, notwithstanding that the arrest occurred before the effective date of the statute. It is important to note in this regard that the law clearly precludes not only an arrest, but also an ensuing prosecution or conviction. However, any other pending charges relating to evidence seized before May 2, 2013 (*e.g.*, distribution or possession with intent to distribute charges) are not affected by the new law, and such prosecutions involving charges that are not specifically enumerated in N.J.S.A. 2C:35-30(a) or 2C:35-31(a) should be pursued in the normal course.

8. Questions and Controversies

Any questions by police officers or agencies or municipal prosecutors concerning the meaning or implementation of the Overdose Prevention Act should be directed to the appropriate County Prosecutor. Any questions by County Prosecutors concerning the statute should be directed to the Director of the Division of Criminal Justice, or his designee.

If a court invokes the statutory immunity feature over the prosecutor's objection (*i.e.*, in circumstances where the feature should not apply according to the explanation of the law provided in this Directive), the municipal or county prosecutor shall, through the appropriate chain of authority, promptly alert the Director of the Division of Criminal Justice or his designee and should take such actions as may be necessary to preserve the State's right to appeal the decision.



John J. Hoffman
Acting Attorney General

c. Thomas R. Calcagni, First Assistant Attorney General
Lee Vartan, OAG Chief of Staff

Appendix G
PAIN MANAGEMENT
GUIDELINES AND CONTRACT

Name: _____

Goals for Pain Management: _____

I, _____, understand that compliance with the following guidelines is important to the continuation of pain treatment by: _____

1. I will take medication at the dose and frequency prescribed. No other pain medications are to be taken unless discussed first with: _____
2. I will comply with my scheduled appointments.
Next appointment: _____
3. No pain medication will be refilled by phone. I understand that pain medication prescriptions will only be refilled at the scheduled appointments.
4. I will not request controlled-substances or any other pain medicine from prescribers other than: _____
5. I will consent to random drug testing.
6. I will protect my prescribed medications. No lost or stolen medications will be replaced.
7. I will tell all my physicians and healthcare professionals that I am receiving pain treatments through and/or from: _____
8. I agree to participate in psychiatric, neuropsychology and substance abuse assessments if recommended, and I will authorize the sharing of those assessments with my physician and other health care professionals.
9. This agreement will be placed in my medical record.
10. I understand that if I have any questions or concerns regarding my pain treatment that I will call my physician at: _____
11. I understand that my physician and other authorized health care professional will periodically access the Prescription Drug Monitoring Database to review the medications that I have filled at pharmacies.

Patient

Date

Physician

Date